



NURSING HOME CHAPLAIN CERTIFICATION COURSE

LESSON PLAN

Course Title: Nursing Home Chaplain

Class Number: HCI#2103

Prepared by: HCI

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Total Hours: 30

Target Population: Chaplains & Ministers

Mandatory Grade: 72%

LESSON GOALS:

- To convey the importance of the nursing home chaplain
- To explain the impetus for the training
- Acknowledge prior historical problems associated with elderly chaplaincy care
- Discuss the procedures necessary during a visit, death or crisis situation for the elderly
- To explain the benefit of a nursing home chaplaincy
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PRESENTATION:

As a Nursing Home Chaplain, it is the primary and basic aim that you should be developing your ability to communicate through the use of this manual. A Nursing Home Chaplain, to effectively communicate through use of this manual, you must be able to:

- Understand the information obtained from the Nursing Home Chaplain manual
- Have a complete understanding of the skills necessary to be an effective nursing home Chaplain
- Remember that your ability to communicate successfully encompasses many complexities, skills, principles, and concepts
- The most important communications skill is your ability to exchange information between you and the people you assist and serve in a timely and effective manner

METHODOLOGY:

Definition: A body of practices, procedures, and rules used by those who work in a discipline or engage in an inquiry; a set of working methods.

It is the aim of Homeland Crisis Institute to provide the basic training necessary for the nursing home Chaplain.

It is not the intention of Homeland Crisis Institute to replace, override or persuade department, or agency policy changes in any way. Our goal is to provide everything in this manual needed to begin your profession of nursing home chaplain.

PREFACE

This manual is intended primarily for use by Volunteer Nursing Home Chaplains who wish to start a faith based Nursing Home Ministry.

Our beliefs influence every aspect of our lives and how we relate to others, especially the elderly or disabled persons confined to a nursing home facility. Everything we do and everything we maintain about our actions should be rooted in God's word. Chaplains wishing to start their own Nursing Home Ministries, will benefit from this manual.

The purpose for this manual is to help those who are seeking to minister to the elderly and the disabled confined into a nursing home facility, but don't know where to start. This manual is not written to replace nursing home facility policy or procedures, only to offer suggestions for starting your own ministry or continuing to maintain the ministry that you have already begun.

This manual is intended to help and encourage those already involved in a nursing home ministry and to give a faith based insight about how to deepen their ministry through understanding the needs of the elderly and disabled. This manual exhibits a biblical view about what God tells us about care of the elderly with a deeper understanding.

This manual is designed to be used as a tool to assist the nursing home chaplain in understanding procedures associated with nursing home ministries. This manual is a self study to be used and consulted as a resource in ministering to the elderly to encourage, stimulate and challenge the chaplain.

Nursing home ministries are becoming more common throughout the country; however, there is not yet, a lot of written material for those wishing to start these types of ministries and unfortunately any knowledge gained, is gained through trial and error.

This manual is intended to offer possible guidelines and suggestions to help those wishing to start a ministry to the elderly and disabled.

Faith Based Nursing Home Chaplains are not Doctors, Medical clinicians, Psychologist, or Psychiatrist and this manual is not intended to place any responsibilities or procedures for medical care or control of any kind, to any person or victim, upon the Nursing Home Chaplain.

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It is the intent Homeland Crisis Institute to provide this material for the nursing home chaplains, ministers or others associated with the nursing home industry.

CHAPTER 1

NURSING HOME HISTORY

(HABER, C., and GRATTON, B. *Old Age and the Search for Security*. New York: Cambridge University Press,)

In the twenty-first century, nursing homes have become a standard form of care for the most aged and incapacitated persons. Nearly 6 percent of older adults are sheltered in residential facilities that provide a wide range of care. Yet such institutions have not always existed; rather, their history and development reflect relatively recent demographic and political realities that shape the experience of growing old.

Before the nineteenth century, no age-restricted institutions existed for long-term care. Rather, elderly individuals who needed shelter because of incapacity, impoverishment, or family isolation often ended their days in an almshouse. Placed alongside the insane, the inebriated, or the homeless, they were simply categorized as part of the community's most needy recipients.

In the beginning of the nineteenth century, women's and church groups began to establish special homes for the elderly persons. Often concerned that worthy individuals of their own ethnic or religious background might end their days alongside the most despised society, they established—as the founder of Boston's Home for Aged Women (1850), explained—a haven for those who were "bone of our bone, and flesh of our flesh".

Advocates for these asylums contrasted their benevolent care with the horrors of those who were relegated to the almshouse. "We were grateful," wrote the organizers of Philadelphia's Indigent Widows' and Single Women's Society, one of the nation's earliest old age homes, in 1823, "that through the indulgence of Divine Providence, our efforts have, in some degree, been successful, and have preserved many who once lived respectfully from becoming residents of the Alms House".

Although designed for those without substantial familial support, these early homes still generally required substantial entrance fees and certificates of good character. Through these policies, the founders strove to separate their own needy poor from, as the Boston founder explained, foreigners who "have taken possession of the public charities as they have of the houses where our less privileged classes formerly resided".

Not surprisingly, perhaps, throughout the nineteenth century the numbers of elderly people who found shelter in these institutions was rather limited. In 1910 the state of Massachusetts, reported that 2,598 persons resided in such asylums.

The great majority of these individuals were widowed and single women who had lived their entire lives, or at least a great proportion, as citizens of the state. Although the institutions were hardly palatial, the amount spent on each resident was far greater than the allocation for each almshouse resident.

Much as their founders had hoped, the nineteenth-century old-age home operated to differentiate the "worthy" old of a particular religion or ethnic group from the most needy and desperate of the aged population.

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As a result, for the most impoverished individuals, the almshouse still served as the last refuge in their old age.

Throughout the nineteenth century, in fact, this institution appeared to play an increasingly important part in the long-term care of the old. Some states, such as Pennsylvania, periodically revoked outdoor relief in the form of money, wood, or clothes, demanding that those in need either struggle on their own or enter an almshouse.

Moreover, as charity advocates removed other, younger paupers to institutions organized to specific needs such as orphanages, work homes, hospitals, or insane asylum, elderly persons became the dominant almshouse residents. Thus, although the proportion of the elderly population that was institutionalized remained stable at about 2 percent, the percentage of elderly within almshouses soared.

In 1880, 33 percent of the national alms-house population was composed of elderly individuals, but by 1923 the proportion had increased to 67 percent. Many of the superintendents of state and local institutions responded to the changing nature of their residents by altering the names of their asylums.

In New York City, in 1903, the Charity Board renamed its public almshouse the Home for the Aged and Infirm. The city of Charleston followed suit in 1913, transforming their almshouse into the Charleston Home. In these institutions, their managers claimed, the old could find everything they needed in their last days.

Despite the name changes and the rosy descriptions that filled the institutions' annual reports, most people hardly looked upon the almshouse as a satisfactory solution to the demands for long-term care for the elderly.

Throughout the early twentieth century, the institution remained a symbol of failure and despair. Poorhouse, according to early twentieth-century social analyst Harry C. Evans, was "a word of hate and loathing, for it includes the composite horrors of poverty, disgrace, loneliness, humiliation, abandonment, and degradation".

Often pointing to the rising percentage of aged individuals within these institutions as proof of increased dependency, pension advocates argued that such institutions clearly revealed the inability of elderly persons to succeed in the industrial world. Most felt that the almshouse, stood as a threatening symbol of the deepest humiliation and degradation before all wage-earners after the prime of life".

By the 1930s, government officials accepted the argument that the rising proportion of elderly persons in almshouses was a sign that older people could no longer compete in the modern world. According to a government study in the 1930s, "the predominance of the aged in the almshouse is a sign of their increasing dependency" (United States Social Security Board).

Despite the fact that the percentage of aged individuals who required such care appeared rather stable, both the tangible horrors of the almshouse and the rising percentage of aged individuals

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within such institutions convinced officials that radical measures needed to be taken. Moreover, many were sure that the almshouse had become a costly solution to the needs of the old.

Assuming that all elderly individuals would eventually need support, they argued that small pensions were a less expensive solution. In the movement to establish the Social Security program, therefore, concerns about the almshouse's central function in providing long-term care played an essential role.

Hoping to eliminate the institution entirely, pension advocates barred any almshouse resident from receiving old-age support. "We were," wrote Pennsylvania's deputy secretary of public assistance, "rather enthusiastic to empty the poorhouses".

Although individuals who resided in a privately funded institution could be beneficiaries of pensions, almshouse residents were barred from such payments. This proviso was essential for establishing both the popularity and legitimacy of Social Security legislation.

In asserting the constitutionality of the Social Security Act (1935), Supreme Court Justice Benjamin Cardozo, writing for the majority, proclaimed that "the hope behind this statute is to save men and women from the rigors of the poorhouse as well as the haunting fear that such a lot awaits them when the journey's end is near".

To a large degree, many of the pension advocates had overestimated the impact of pensions on the lives of the needy elderly. Most had simply assumed that, with monthly annuities, individuals could live independently. They saw little reason to reform the poorhouse or support it with financial resources.

A few, however, such as aging advocate Homer Folks, argued that only about 15 percent of the almshouse population were in the institution because of strict financial need. "The others," he explained, "are physically infirm and sick, and have various kinds of ailments that require personal attention of the kind that you could not get in an individual home; [they] require nursing or medical attention . . . in some sort of institution".

Nonetheless, the symbol of the almshouse was so powerful that Folks' argument had little public support. Despite its relatively small inmate population, the almshouse stood as a tangible sign of a despised welfare system. There seemed little doubt that it needed to be eliminated.

In eradicating the almshouse, therefore, pension legislation had an unforeseen consequence. By barring almshouse inmates from payments, aged individuals in need of long-term care were forced to seek shelter in private institutions.

In Charleston, for example, while some of the almshouse residents were able to leave the institution and, with the support of pensions, live on their own, many were compelled to enter private, often unregulated, sanitariums.

In some cases, such a move was more a change in name than in place. In Kansas, for example, immediately following the enactment of Social Security,

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officials transferred well-established county homes into private control, although neither the residence nor its supervisors changed. Most importantly, however, the inmates could now be classified as recipients of private care, and the institution was able to receive residents' monthly annuities.

By the 1950s, the intent of policymakers to destroy the hated almshouse had clearly succeeded. Most poorhouses had disappeared from the landscape, unable to survive once their inmates no longer received federal annuities.

As a result, and due to the lobbying of public hospital associations, Congress amended Social Security to allow federal support to individuals in public facilities. New legislation, including with the Medical Facilities Survey and Construction Act of 1954, allowed for the development of public institutions for the neediest older adults.

For the first time, both public and private nursing-home residents were granted federal support for their assistance. As Homer Folks had predicted, not all elderly individuals could be supported in their own homes with monthly pensions; many incapacitated older adult's required long-term care.

In 1965, the passage of Medicare and Medicaid provided additional impetus to the growth of the nursing-home industry, which, while it had been increasingly steadily since the passage of Social Security, grew dramatically. Between 1960 and 1976, the number of nursing homes grew by 140 percent, nursing-home beds increased by 302 percent, and the revenues received by the industry rose 2,000 percent.

To a great extent, this growth was stimulated by private industry. By 1979, despite the ability of government homes to provide care, 79 percent of all institutionalized elderly persons resided in commercially run homes.

According to investigations of the industry in the 1970s, many of these institutions provided substandard care. Lacking the required medical care, food, and attendants, they were labeled "warehouses" for the old and "junkyards" for the dying by numerous critics.

The majority of them, proclaimed Representative David Pryor in his attempt to initiate legislative reform in 1970, were "halfway houses between society and the cemetery". And, like the almshouses of old, people feared ending their days in the wards of these institutions and relatives felt guilty for abandoning their elders to nursing-home care.

Beginning in 1971, therefore, policymakers began to enact numerous government regulations in order to control the quality of long-term care. In 1971 the Office of Nursing Home Affairs provided a structure to oversee numerous agencies responsible for nursing-home standards.

In 1972, reforms of Social Security established a single set of requirements for facilities supported by Medicare and for skilled-nursing homes that received Medicaid.

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Although this limited the ability of most individuals to enter skilled-nursing facilities, it increased the demand for intermediate-care facilities. Other amendments to the Older American Acts in 1973 and 1987 provided and strengthened statewide nursing home ombudsman programs. Nursing homes residents and their families now had a secure way of voicing any institutional complaints

These policies, however, did not uniformly raise the standards of all nursing homes, nor did they eliminate the fear expressed by many of the older adults who faced nursing-home admission with dread. Yet, as the percentage of the population over eighty-five has continued to grow, nursing home care has become an increasing reality for many of the nation's oldest old.

By 2000, nursing homes had become a 100 billion dollar industry, paid largely by Medicaid, Medicare, and out-of-pocket expenses; and although only 2 percent of all elderly individuals between sixty-five and seventy-four reside in such institutions, the proportion of those over eighty-five increased to 25 percent.

While these aging individuals no longer face the horrors of the almshouse, the development of the modern-day industry reflects its historical roots. In establishing monthly annuities for the old and disqualifying all residents of public institutions, the creators of Social Security took direct aim at the despised poorhouse.

In their initial policies, New Dealers were anxious to sever the connection between old age and pauperism. In barring all residents of public institutions from receiving pensions, however, they clearly underestimated the proportion of elderly persons who required residential support. As a result, they did not initially provide for public asylums or regulate the quality of private care.

Although recent legislation has attempted to control nursing homes, and federal funds such as Medicaid contribute to their assistance, the problems that face long-term care for older adults are clearly tied to their historical development. In shutting the almshouse door, policymakers gave birth to the modern nursing-home industry.

NOTES

CHAPTER 2 THE BIBLE'S PERSPECTIVE ON AGING

To grasp in full the sense and value of old age we need to open the Bible. Only the light of the Word of God, in fact, enables us fully to fathom the spiritual, moral and theological dimension of this stage of life. The following biblical passages are presented with the aim of prompting a reconsideration of the meaning of the third and fourth stages. They are accompanied with observations and reflections on the challenges that older people face in contemporary society.

You will honor the person of the aged (Lev 19:32)

In the Scriptures respect for older people is transformed into a law, a commandment: "You will stand up in the presence of grey hairs and fear your God" and again: "Honor your father and your mother" (Deut 5:16).

We must strive to counter the widespread contemporary tendency to ignore and marginalize older people. We need to "educate" the new generations not to abandon them; young people, adults and older people have a need for each other.

Our ancestors have told us, of the deeds you did in their days, in days of old, by your hand (Ps 44:2)

The lives of the patriarchs are particularly eloquent in this regard. When Moses had the experience of the burning bush, God appeared to him as follows: "I am the God of your ancestors, the God of Abraham, the God of Isaac and the God of Jacob" (Ex 3:6).

God links his own name with the great patriarchs, who represent the legitimacy and guarantee of the faith of Israel. In the Old Testament, the son, the young person, always encounters, indeed we might almost say "receives" God from his fathers, from his elders.

In the above-cited passage, the recurrent expression "the God of..." denotes that each of the patriarchs had his own personal experience of God. And this experience, which was the legacy of the patriarchs, was also the reason for their youthfulness of spirit and their serenity in the face of death. Paradoxically, it is older people who define the present by transmitting to others what they have received: in a world that extols a condition of eternal youthfulness, shorn of memory or future, this fact cannot but give us pause for thought.

In old age they will still bear fruit (Ps 92:14)

The power of God can be revealed in old age, even if it is characterized by physical impediments and difficulties. "God chose those who by human standards are fools to shame the wise; he chose those who by human standards are weak to shame the strong, those who by human standards are common and contemptible, indeed those who count for nothing to reduce to nothing all those that do count for something, so that no human being might feel boastful before God" (1 Cor 1:27-29).

God's plan of salvation is also fulfilled in the fragility of bodies that are weak, barren, impotent and no longer young.

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It was from Sarah's barren womb and Abraham's centenarian body that the Chosen People was born (cf. Rom 4:18-20). And, similarly, it was from Elizabeth's barren womb and the elderly Zechariah that John the Baptist, the precursor of Christ, was born (Luke 1:5-25).

Older people, even when their lives take on the semblance of weakness, may, with good reason, consider themselves instruments of the history of salvation: "I shall satisfy him with long life, and grant him to see my salvation" (Ps 91:16), promises the Lord.

Remember your Creator while you are still young, before the bad days come, before the years come which, you will say, give you no pleasure (Eccles 12:1)

This biblical approach to old age is striking for its disarming objectivity. Moreover, as the Psalmist recalls, our lives are over in a breath, nor is it always gentle and painless: "The span of our life is seventy years, eighty for those who are strong, but their whole extent is anxiety and trouble, they are over in a moment, and we are gone" (Ps 90:10).

The words of Qoheleth in Ecclesiastes, providing a lengthy description of physical decline and death in symbolical images, paint a somber picture of old age. Holy Scripture reminds us here not to harbor any illusions about a period of life that involves hardships, tribulations and sufferings. And it reminds us to look to God throughout our whole life, since he is the goal to which our human pilgrimage is always directed, and especially so in the moment of fear which seizes us when old age is experienced as an ordeal.

Abraham breathed his last, dying in a happy ripe age, old and full of years, and he was gathered to his people (Gen 25:8)

This biblical passage is of particular relevance for our times. The contemporary world has lost sight of the truth about the meaning and value of human life which God impressed on the conscience of man ever since the creation and with it the full significance of old age and death.

Today, death has lost its sacred character, its sense of fulfillment. It has become taboo. Every effort is made to sweep it under the carpet, to make sure that it does not disturb. Even its setting has changed: it is no longer at home that most people die: older people in particular, increasingly separated from their own human community, ever more frequently die in hospitals or in institutions.

Mourning rites and many forms of piety towards the dead are becoming increasingly rare, especially in the cities. Numbed by the daily images of death presented by the media, people today do everything in their power to avoid coming to terms with a reality which causes them only distress, anxiety and fear.

It is inevitable therefore that, as their own death approaches, they are often alone. But the Son of God, who became man, reversed the significance of death: he flung open the doors of hope to those who believe in him: "I am the resurrection.

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Anyone who believes in me, even though that person dies will live, and whoever lives and believes in me will never die” (Jn 11:25-26). In the light of these words, death no longer a condemnation, no longer a meaningless epilogue of life signifying nothing is revealed as a time of hope: the true and certain hope of coming face to face with the Lord.

Teach us to count up the days that are ours, and we shall come to the heart of wisdom
(Ps 90:12)

According to the Bible, one of the “chrisms of longevity” is wisdom. But wisdom is no automatic prerogative of old age. It is a gift of God, which older people must accept and set as their goal. Only in pursuit of that goal can they attain the wisdom of heart that enables them to “count how few days (they) have”, that is, to live the time that Providence grants to each one of us with a sense of responsibility.

The essence of this wisdom is the discovery of the profound meaning of human life and of the transcendent destiny of the person in God. And if this is important for the young, how much more so is it for older people, who are called to direct their lives without losing sight of the “one thing that is necessary” (Luke 10:42).

In you, Yahweh, I take refuge; I shall never be put to shame (Ps 71:1)

This psalms, striking for its beauty, is only one of the many prayers of older people that we find in the Bible and that testify to the religious feelings felt by the soul in the presence of the Lord.

Prayer is the principal means for a spiritual understanding of life proper to older people. Prayer is a service. It is a ministry that older people may perform for the good of the whole Church and the world. Even the most infirm and handicapped of them can pray. Prayer is their strength, it is their life.

Through prayer they can break down the walls of isolation, emerge from their condition of helplessness, and share in the joys and sorrows of others. Prayer is of central importance. It also touches on the question how an older person can become contemplative in spirit. An older person, confined to bed and reduced to the end of his or her physical strength, can, by praying, become like a monk, a hermit. And through prayer he or she can embrace the whole world.

It seems impossible that a person, who has always lived an active life, can become contemplative. Yet there are moments in life when a frame of mind receptive to contemplation is developed that can benefit the whole of the human community. And prayer is the means par excellence to this end, because “there is no renewal, not even social, which does not begin from contemplation.

The encounter with God in prayer introduces into the course of history a power which touches hearts, leads them to conversion and renewal, and so becomes a powerful historical force transforming social structures”.

CHAPTER 3

MARGINALIZATION

Of the various problems that commonly afflict older people today, one, perhaps more than any other, injures the dignity of the person: marginalization. The development of this problem, a relatively recent one, has found a fertile breeding ground in a society that cultivates nothing but material success and the glossy image of perennial youth, to the virtual exclusion of those who no longer possess these requisites.

The factors that conspire to consign many older people to the fringes of the human community and civil life are many: evasion of responsibility at the institutional level and consequent social inadequacies; poverty or a drastic reduction of income and of the necessary financial resources to secure a decent standard of living and appropriate levels of care; and the progressive removal of older people from their own family and social environment.

The most painful dimension of this marginalization, however, is the lack of human relations. Older people suffer not only by being deprived of human contact, but also from abandonment, loneliness and isolation.

And as their interpersonal and social contacts are diminished, so their lives are correspondingly impoverished; they are deprived of the intellectual and cultural stimulus and enrichment they need.

Older people experience a sense of impotence at being unable to change their own situation, due to their inability to participate in the decision-making processes that concern them both as persons and as citizens. The net result is that they lose any sense of belonging to the community of which they are members.

The problem concerns everyone. It concerns the whole of society. And it is society, at its various institutional levels, that needs to intervene to ensure effective protection, including juridical protection, for that not negligible part of the population that lives in a situation of extreme social, economic and cultural deprivation.

ASSISTANCE

Still today, indeed increasingly so, recourse is hard to the system of institutional care to assist and treat older people who are infirm, no longer self-sufficient, without any family to look after them, and without adequate financial resources to look after themselves.

The confinement of older people in such institutional structures may translate itself into a kind of segregation from society. Some social and welfare policies and the institutions to which they gave rise, however understandable in the light of the different social and cultural context of the past, have now been rendered obsolete and in conflict with a new human consciousness.

A society, aware of its responsibilities towards the older generations who have helped to make it what it is, must strive to create institutions and services adapted to their real needs. Wherever feasible, older people should be given the chance to remain within their own environment by means of such forms of support as home-help, day-care, day-centers, etc.

In this context, a mention of retirement homes is not out of place. By the very fact that they provide accommodation to older persons who have been forced to abandon their own homes, such residential structures are being increasingly urged to respect the autonomy and the personality of each individual, to give each of them the chance to pursue activities linked to his or her own interests, to provide all the forms of care and treatment required by old age, and to give to the accommodation they provide an atmosphere as close to that of the family as possible.

EDUCATION AND EMPLOYMENT

The mentality of our time tends to reinforce the close link between education and professional activity. That is the reason for the lack of educational programs for older people. In an age in which ongoing training and re-skilling are an essential prerequisite for being able to keep pace with the rapid progress of technological development and derive material benefits from it, older people, whose level of education is no longer geared to the labor market are excluded from policies of continuing education. This exclusion ignores their growing needs and aspirations in this field.

Separation from the world of work and from everything related to it occurs today in an over-brusque and inflexible manner. Only rarely does it coincide with the needs, opportunities and preferred choices of the older people concerned.

Many older people seek in vain a form of employment; they frequently do so to compensate for inadequate or non-existent pensions. This need for financial security must be satisfied: older people must be given the chance to do something. They must be enabled to express their own creativity and to develop the spiritual dimension of their lives.

That compulsory retirement can trigger off a process of premature ageing now seems demonstrated. Conversely, the pursuit of some form of employment beyond retirement age would have a beneficial effect on the quality of life of older people.

The spare time that they have on their hands is therefore the first resource that needs to be addressed. An active role needs to be restored to them. Their access to the new technologies, and employment in socially useful forms of work, need to be promoted; and opportunities of engaging in forms of volunteer work and services of benefit to the community, opened up to them.

PARTICIPATION

It is an established fact that older people, if they are given the opportunity, do participate actively in the life of the community, both at the civil and at the cultural and associational levels. This is confirmed by the numerous positions of responsibility held by older persons, for example in the field of the volunteer services, and by their far from negligible political influence.

Steps must be taken to correct the lack of representation of older people, and to remove the prejudices and misconceptions that have damaged their image in our time.

Older people must be enabled to influence the policies that concern their life, but also those that concern society in general. They must be helped to do so through specific organizations, and through appropriate forms of political and trade-union representation.

The creation of associations for older people must therefore be encouraged and those already existing are supported. Such associations, as John Paul II has stressed, “must be recognized by the authorities in society as a legitimate expression of the voice of older people, and especially of those older people who are most dispossessed”.

To stem the culture of indifference, rampant individualism, competitiveness and utilitarianism which are now threatening all areas of society, and to remove any form of segregation between the generations, a new mentality, a new attitude, a new mode of being, a new culture need to be developed. A form of prosperity and of social justice needs to be pursued that is compatible with the objective of defending the centrality of the human person and his dignity.

THE CHURCH AND OLDER PEOPLE

“The life of older people helps to cast light on the scale of human values; to reveal the continuity of the generations and wonderfully to demonstrate the interdependence of the People of God”. It is notably in the Church that this interdependence is expressed: it is there that the various generations are called to share in the plan of God's love by reciprocally exchanging the gifts with which each person is enriched by grace of the Holy Spirit. To this exchange of gifts older people bring religious and moral values that represent a rich spiritual endowment for the life of Christian communities, families and the world.

Religious practice occupies a key place in the life of older persons. The third stage seems particularly conducive to transcendental values. Confirmation of this is given, among other things, by the frequent participation of older people in liturgical celebrations, by the unexpected return of many of them to the Church after long years of absence, and by the important role played by prayer in their lives.

Prayer represents in fact an inestimable contribution to the spiritual resources of devotion and sacrifice, from which the Church copiously draws and which need to be fostered both within Christian communities and within families.

Often lived in a simple way, but not for that reason any less profound, the religious faith of older people of both sexes is highly diversified; this is also determined by the relative strength of their faith in their earlier life.

At times, it is distinguished by a kind of fatalism: in such cases, suffering, disabilities, illnesses, the losses inseparable from this phase of life, are regarded, if not as divine punishments, at least as signs of a God who is no longer benevolent. The ecclesial community has the responsibility to purify this fatalism by helping to develop the religious faith of older people and by restoring a horizon of hope to it.

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Christian's play a role of primary importance in this. It is the job of Christians to purge faith of fear, to overcome the image of a wrathful God, and to lead the older person to discover the God of love. Familiarity with Holy Scripture, a deeper knowledge of the content of our faith, and meditation on the death and resurrection of Christ will help older people to overcome a punitive conception of God, which bears no relation to his love as a Father.

By participating in the liturgical and sacramental prayer of the Christian community and by sharing its life, older people will increasingly learn to understand that the Lord is not uncaring, not indifferent to human sorrow or to the personal difficulties they encounter in the course of their lives.

It is the duty of the Church to announce to older people the Good News of Jesus, who is revealed to them just as he was revealed to Simeon and Anna. Jesus comforts them with his presence. He causes their hearts to rejoice at the fulfillment of hopes and promises that they had kept alive in their hearts (Luke 2:25-38).

It is the duty of the Church to give older people the chance to encounter Christ. They must help them to rediscover the significance of their Baptism, by means of which they were buried together with Christ and joined him in death, "so that as Christ was raised from the dead by the Father's glorious power, they too, should begin living a new life" (Rom 6:4) and find in him the meaning of their present and future life.

For hope is rooted in faith in this presence of the Spirit of God, "the Spirit of him who raised Jesus from the dead" and who will also give life to our own mortal bodies. Consciousness of rebirth in Baptism enables older people to preserve in their hearts a childlike awe before the mystery of the love of God revealed in the creation and redemption.

It is the duty of the Church to instill older people with a deep awareness of the task they too have of transmitting the Gospel of Christ to the world, and revealing to everyone the mystery of his abiding presence in history. It is also their duty to make them aware of their responsibility as privileged witnesses, who can testify, both before human society and before the Christian community, to God's fidelity: he always keeps the promises he has made to man.

The pastoral task of evangelizing or re-evangelizing older members of the community must aim at fostering the spirituality that is peculiar to this age of life: i.e. spirituality based on the continual rebirth that Jesus himself recommended to the elderly Nicodemus.

Jesus urged Nicodemus not to let old age stand in the way of rebirth. To be reborn to a life that is ever new and full of hope, we don't need to go back to our mother's womb: we need to be "born from above", by opening ourselves up to the gift of the Spirit; for "what is born of human nature is human; what is born of the Spirit is spirit" (John 3:6).

Christ's call to holiness is addressed to all his disciples, in every phase of human life: "You must therefore set no bounds to your love, just as your heavenly Father sets none to his" (Matt 5:48).

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In spite of the passing of years, which risks dampening enthusiasm and draining away energy, older people must therefore feel themselves more than ever called to persevere in the search for Christian holiness: Christians must never let apathy or tiredness impede their spiritual journey.

This pastoral task involves the need to train priests, assistants and volunteers, young people, adults, older people themselves, for service to older people; pastoral workers who are imbued with humanity and spirituality, and who have the ability to enter into rapport with people in the third and fourth ages, and to respond to their often very individualized human, social, cultural and spiritual needs.

The needs of older people must also be addressed by the various branches of specialized pastoral care. These include the family apostolate, which cannot ignore the bonds between older people and their family, not only at the level of social services, but also at that of religious life; the various forms of social ministry; and the apostolate of health-care workers.

The contribution that older people themselves can make is also indispensable to this pastoral work. From their rich endowment of faith and of experience they can draw things old and new to the advantage not only of themselves, but also of the whole community.

Far from being the passive recipients of the Church's pastoral care, older people are irreplaceable apostles, especially among their own age group, because no one is more familiar than they with the problems and the feelings of this phase of life.

Particular importance is being given today, moreover, to the apostolate of older people among people of their own age group in the form of witness of life.

It is not of secondary importance to be able to show, in concrete terms, that this season of life, when lived in a Christian way, has a value of its own, enriched by the profound significance that it acquires through the whole course of human existence. No less important is the direct preaching of the Word of God by one older person to another, or to the up-and-coming generations of children and grandchildren.

By word and by prayer, and also by the renunciations and sufferings that advanced age brings with it, older people have always been eloquent witnesses and apostles of the faith in Christian communities and in families, sometimes in conditions of persecution, as was the case, for example, under the atheist totalitarian regimes of the Communist bloc in the 20th century.

Who has not heard of the Russian “babushkas”, who kept alive the faith during the long decades when any expression of religious faith was equivalent to a criminal activity, and who transmitted it to their grandchildren?

It was thanks to their courage and steadfastness that faith was not completely extinguished in the former Communist countries and that a basis now exists, even though a precarious one, for the new evangelization to build on.

The International Year of Older Persons offers a valuable occasion to remember these extraordinary older people, both men and women, and their silent and heroic witness. Not only the Church, but human civilization is greatly indebted to them.

An important role in promoting the active participation of older people in the work of evangelization is now played by the Church-based associations and the ecclesial movements, “one of the gifts of the Spirit, to the Church, of our time”.

Many older people have already found an extremely fertile field for their formation, commitment and apostolate in the various associations present in our churches. They have become real protagonists within the Christian community. Nor is there any lack of other groups, communities and movements working more specifically in the world of the third stage.

Thanks to their chrisms, all these associations create an environment in which communion can thrive between the various generations and a spiritual climate that helps older people to maintain their spiritual vitality and youthfulness.

OLD AGE IS A BLESSING FROM GOD

Attitudes toward aging in general and toward elderly people in particular are especially important for Christians. The Bible teaches that old age is the blessing of God

1. Old age may be the fruition of a moral life and an indication of God’s favor. “Follow the whole instruction the Lord your God has commanded you, so that you may live, prosper, and have a long life in the land you will possess” (Deuteronomy 5:33).
2. Old age is a general part of God’s purpose for a normal life. “He took his last breath and died at a ripe old age, old and contented, and he was gathered to his people” (Genesis 25:8). “David son of Jesse... died at a good old age, full of days, riches, and honor...” (1 Chronicles 29:26, 28). “Then Job died, old and full of days” (Job 42:17).
3. Old age may be one reward of those who honor their parents. “Honor your father and your mother so that you may have a long life in the land that the Lord your God is giving you” (Exodus 20:12). “Children, obey your parents in the Lord, because this is right.
4. Honor your father and mother which is the first commandment with a promise that it may go well with you and that you may have a long life in the land” (Ephesians 6:1). “If you walk in my ways and keep My statutes and commandments just as your father David did, I will give you a long life” (1 Kings 3:14). “Gray hair is a glorious crown; it is found in the way of righteousness” (Proverbs 16:31).

CHAPTER 4 CHARACTERISTICS OF OLD AGE

In the Bible, the aged are perceived as resourceful people with valuable gifts to share for the good of everyone.

5. Wisdom is an attribute of the aged who depend upon God.
Happy is a man who finds wisdom and who acquires understanding... She is more precious than jewels; nothing you desire compares with her. Long life is in her right hand; in her left, riches and honor” (Proverbs 3:13, 15-16).
“The fear of the Lord is the beginning of wisdom and the knowledge of the Holy One understands. For by Wisdom your days will be many, and years will be added to your life” (Proverbs 9:10-11).
6. Wise counsel to the younger is a duty of the aged.
“Hear this, you elders; listen, all you inhabitants of the land. Has anything like this ever happened in your days or in the days of your ancestors? Tell your children about it, and let your children tell their children and their children the next generation” (Joel 1:2-3).
“Remember the days of old; consider the years long past. Ask your father, and he will tell you, your elders, and they will teach you” (Deuteronomy 32:7).
“In the same way, older women are to be reverent in behavior, not slanderers, not addicted too much wine. They are to teach what is good, so that they may encourage the young women to love their husbands and children, to be sensible, pure, good homemakers, and submissive to their husbands, so that God’s message will not be slandered” (Titus 2:3-5).
7. The aged have continuing moral responsibilities.
“Older men are to be self-controlled, worthy of respect, sensible, and sound in faith, love, and endurance. In the same way, older women are to be reverent in behavior, not slanderers, not addicted too much wine. They are to teach what is good” (Titus 2:2-3).

RESOURCES FOR THE AGED

Numerous problems, economic, physical, mental, and spiritual, confront the aged. Resources for meeting these problems are set forth in the Bible.

8. God has promised His abiding presence.
“Listen to me, house of Jacob, all the remnant of the house of Israel, who has been sustained from the womb, carried along since birth. I will be the same until your old age, and I will bear you up when you turn gray. I have made you, and I will carry you; I will bear and save you” (Isaiah 46:3-4).
9. God gives strength to endure suffering and infirmity.
“Therefore, since Christ suffered in the flesh, arm yourselves also with the same resolve because the One who suffered in the flesh has finished with sin in order to live the remaining time in the flesh, no longer for human desires, but for God’s will” (1 Peter 4:1-2).
“Now I rejoice in my sufferings for you, and I am completing in my flesh what is lacking in Christ’s afflictions for His body, that is, the church” (Colossians 1:24).
“So those who suffer according to God’s will should, in doing good, entrust themselves to a faithful Creator” (1 Peter 4:19).

10. God gives deliverance from the fear of death.

“For I am persuaded that neither death nor life, nor angels nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor any other created thing will have the power to separate us from the love of God that is in Christ Jesus our Lord!” (Romans 8:38-39).

“Look! God’s dwelling is with men, and He will live with them. They will be His people, and God Himself will be with them and be their God. He will wipe away every tear from their eyes. Death will exist no longer; grief, crying, and pain will exist no longer, because the previous things have passed away” (Revelation 21:3-4).

“Now when this corruptible is clothed with incorruptibility, and this mortal is clothed with immortality, then the saying that is written will take place: Death has been swallowed up in victory. O Death, where is your victory? O Death, where is your sting? Now the sting of death is sin, and the power of sin is the law. But thanks be to God, who gives us the victory through our Lord Jesus Christ!” (1 Corinthians 15:54-57).

CARE OF THE AGED

Society has a moral responsibility to care for its aging members. Christians are to be especially sensitive to the needs of the aged and active in ministries to them.

11. The aged deserve kindness and respect.

“Do not rebuke an older man, but exhort him as a father, younger men as brothers, older women as mothers and with all propriety...” (1 Timothy 5:1-2).

“You are to rise in the presence of the elderly and honor the old... I am the Lord” (Leviticus 19:32).

“Listen to your father who gave you life, and don’t despise your mother when she is old” (Proverbs 23:22).

12. Families have an obligation to provide for their aged members.

“Now if anyone does not provide for his own relatives, and especially for his household, he has denied the faith and is worse than an unbeliever” (1 Timothy 5:8).

13. Churches have special responsibilities for the aged.

“If any believing woman has widows, she should help them, and the church should not be burdened, so that it can help those who are genuinely widows” (1 Timothy 5:16).

CONCLUSION

Christian ministry to the aged involves caring for each elderly individual as a person created in the image of God (Genesis 1:27) and as a person for whom Christ cares (Matthew 25:31-46).

In the Bible, old age is considered the positive and good fulfillment of a life devoted to God. Both the blessings and responsibilities of aging are to be accepted with gratitude and in a sense of stewardship, “For God has not given us a spirit of fearfulness, but one of power, love, and sound judgment” (2 Timothy 1:7).

PASTORAL CARE AND THE ELDERLY

QUALIFICATIONS FOR GOD'S SERVANT

Our father has good works prepared for each of us to do. Works that delight him, bring us joy and satisfaction and bless others with a personal knowledge of his love and mercy.

More than his servants are his children, who God wants to use to serve him and bring his glory. He created each of us as a distinct individual with qualities and gifts that he prepared us with and he expects that we should be striving to minister to others using these gifts and qualities.

God loved us enough to give his only Son to die for our sins. Knowing and experiencing that love is critical as we carry on a ministry to the elderly. Without continually being sustained by God's abiding love, without drawing deeply from that well of salvation, there is no strength, knowledge, no joy and no life enough to carry out that command.

God's word is very clear about what it means hear and follow Jesus. Matthew 25:31-46 gives us practical ways in feeding the hungry, showing hospitality to strangers, and giving to the poor, visiting the sick and elderly. You must be willing to be a follower and doer of God's word.

The quality that was a God given gift is characterized by affliction that comes from knowing Christ and believing in his resurrection. The Bible tells us in Philippians 2 that Christ gave up his heavenly home to become a servant. So how should we be any different. (2 Cor. 1-3) teaches us not to be bitter about suffering: let it prepare us to comfort others.

When you show your love to the elderly, be committed and make sure that your motives are sincere. Negative results increases depression and behavioral disorders. Consistent worship, help and love shows that we are there to carry the mission of Jesus Christ.

Your role as a servant requires that you accept people as they are. It's okay to be weary and confused, weak and angry and ask yourself what you can do about the situation. Remember: we are commanded to hear one another's burdens (Gal. 6:2).

Sharing "the joy and hope, the grief and anguish of our time", the Church strives with maternal solicitude to support older people through forms of assistance and charitable activities. They also urge older people to continue their own evangelizing mission, which it is not only possible and necessary, but which is in some sense a specific and original task of this age of life.

The expected retirement of persons from various professions and the workplace provides older people with a new opportunity to get involved in church activities and involved in this task is their determination to overcome the temptation of taking refuge in nostalgia in a never-to-return past or fleeing from present responsibility because of difficulties encountered in a world of one novelty after another.

They must always have a clear knowledge that the older person's role in society does not stop at a certain age at all, but at such times knows only new ways of application.

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Arriving at an older age is to be considered a privilege: not simply because not everyone has the good fortune to reach this stage in life, but also, and above all, because this period provides real possibilities for better evaluating the past, for knowing and living more deeply the mystery, for becoming an example for the whole People of God”.

The Christian community, for its part, is called to respond to the greater participation which older people would like to have by turning to account the “gift” they represent as witnesses of the tradition of faith, teachers of the wisdom of life and workers of charity.

Society must therefore re-examine its opinion on behalf of older people, and open it up to their participation and collaboration. Of the various areas that best lend themselves to the witness of older people in society, the following should not be forgotten:

Charitable activities:

A large proportion of older people have enough physical, mental and spiritual energy to devote their own time and talents in a generous way to the various activities and programs of the volunteer services.

Apostolate:

Older people can make a major contribution to the preaching of the Gospel as witnesses to Christian life.

Liturgy:

Many older people already contribute effectively to the service of places of worship. If suitably trained, they could, in larger numbers, play the role of deacons, teachers and leaders, and fulfill the ministry of lector and altar server.

The growth of many religious associations and communities, which represent a great enrichment for the Church, is also due to a form of participation that integrates the various generations, and manifests the richness and fruitfulness of the different gifts given to us by the Holy Spirit.

The family:

Older people represent the “historical memory” of the younger generations. They are the bearers of fundamental human values.

Where this memory is lacking, people are rootless; they also lack any capacity to project themselves with hope towards a future that transcends the limits of the present. The family and hence society as a whole will benefit greatly from a revaluation of the educational role of older people.

Contemplation and prayer:

Older people should be encouraged to consecrate the years that remain hidden in the mind of God to a new mission illuminated by the Holy Spirit. In this way they may give rise to a stage of human life which, in the light of the mystery of the Lord, is revealed as the richest and most promising of all.

Older people, with the wisdom and experience which are the fruit of a life-time, have entered upon a time of extraordinary grace which opens to them new opportunities for prayer and union with God. Called to serve others and to offer their lives to the Lord and Giver of Life, new spiritual powers are given to them”.

Trials, illnesses and suffering:

These experiences represent the “fulfillment”, in body and heart, of the passion of Christ for the Church and for the world (Col 1:24). It is important that older people be helped to accept these crosses in a spirit of humble submission to the will of God, in imitation of the Lord. But this will only be possible in proportion as they feel loved and esteemed.

Devotion to the weak, to the suffering, to the disabled is a duty of the Church and is proof of the maternal care. A whole series of services and forms of pastoral care should therefore be provided to ensure that older people do not feel useless and a burden, and to help them to accept their aging as a means of encountering the mystery of God and of man.

Commitment to a “culture of life”:

Illness and suffering are privileged means for reminding us of the inalienable principle of the sacredness and inviolability of life. The mission of Jesus itself, with its many cases of healing the sick and disabled, shows how much God has at heart not only the spiritual but also the bodily life of man (Luke 4:18).

Man cannot arbitrarily choose to live or die, or decide on the life or death of others: that is a choice which only he in whom “we live, and move and exist” (Acts 17:28; Dt 32:39) can make.

The exclusion of, or blindness to, the transcendental dimension, typical of our own times, is increasingly promoting a tendency to appreciate life only as it produces pleasure and well-being, and to regard suffering as an intolerable burden which needs to be eliminated at all costs.

Death, regarded as “absurd” if it curtails a life still full of promising and exciting potential, is regarded as “liberation”, to be claimed as a right, if it terminates a life seen as meaningless because overwhelmed by suffering. It is this attitude that forms the cultural context of euthanasia, which the Church condemns as “a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person”.

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In view of the great diversity in the situations and conditions of the life of older people, the Church's pastoral ministry to those in the third and fourth ages ought to involve the implementation of a series of measures aimed at achieving the following objectives:

Consciousness-raising:

The Church should heighten awareness of the needs of older people, and help them contribute to the community by performing activities appropriate to their condition.

This will permit the formulation of qualified forms of intervention. It will also sensitize and involve both the ecclesial and civil communities; and focus attention on those options that are revealed as evangelically and culturally more valid, also with a view to a renewal of the Church's charitable works and forms of assistance.

Countering attitudes of withdrawal:

Older people must be helped to overcome the indifference and mistrust that hamper their active participation and solidarity.

Promoting integration:

Older people must be integrated, without any form of discrimination, into the Christian community. No one should be deprived of the grace of God, the preaching of the Word, the consolation of prayer or the witness of charity.

Service of older people in the community:

The life of the Christian community must be organized to encourage the participation of older persons and to foster the capacities of each. The church should set programs for ministry to older people and churches should be encouraged to develop spiritual, community and recreational activities for this age group.

Participation in the Church:

Older people must be helped to participate in the celebrations, Sacraments, retreats and spiritual exercises. Steps should also be taken to ensure that their involvement in such events be not hindered by physical barriers, or by the lack of specialized personnel to accompany and assist them.

Spiritual care:

The care and assistance of older people who are disabled, or no longer in full possession of their physical or mental faculties, should also involve spiritual care; through prayer and communion in the faith, it should testify to the inalienable value of life, even when it is reduced to a terminal condition.

Sacrament of the sick and dying:

For certain denominations, the administration of the anointing of the sick must be fostered in a special way, and preceded by appropriate. Where circumstances permit, it is desirable that members of the clergy incorporate the anointing the sick in community celebrations both in the churches and in the places of residence in which older people live.

Comforting the terminally ill:

Efforts should be made to resist the tendency to abandon the dying and leave them without religious assistance and human comfort. This task is not only incumbent on chaplains, whose role is fundamental, but also on the families and communities to which older people belong.

Caring for those of other faiths:

Particular attention should be devoted, in a spirit of charity, and to the elderly of other religious faiths in order to help them live their faith; Christians should not be shy of witnessing to their own faith, in a spirit of brotherhood and solidarity, to older people who are non-believers.

A rightful place in society and in the family:

Older people have a right to a place in society and even more so to an honored place within the family. The family is called to be a communion of persons. It needs to be reminded of its special mission to foster, manifest and communicate love, and its duty to provide assistance to its weaker members, not least the elderly, and surround them with affection.

Caring for older people living in public or private residential structures: the uprooting of older people from their natural families would be less traumatic if the community were to maintain links with them. The church community, “family of families”, must turn itself into a service of older people and their problems.

It must also seek to co-operate with the authorities responsible for running such residential homes with a view to finding appropriate ways to ensure the involvement of the volunteer services, the provision of cultural activities and religious service.

Intergenerational solidarity:

The young members of groups, associations and movements present in the community must be educated to show solidarity towards the elder members of the community. Such intergenerational solidarity is also expressed in the companionship that the young are able to offer to the old.

Young people who have opportunities for involvement with older people will appreciate the value of a formative experience by which they gain in maturity and are helped to develop an awareness of others that remains with them for the whole of their life.

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In a society in which selfishness, materialism, and consumerism and in which the means of communication serve little to alleviate the growing loneliness of man, such values as selflessness, dedication, friendship, acceptance and respect represent a challenge to those, not least the young, who are striving for the birth of a new humanity.

THE MINISTRY AND THE ELDERLY

Whenever we turn to the bible, we consistently see exhortations to honor the aged. In the Ten Commandments (Ex.20:17) we find the well known commandments to honor father and mother, whatever their age.

Other commandments prohibit afflicting or taking advantage of the widow. (Ex. 22:22). Leviticus 19:32 makes our attitude to the elderly abundantly clear. "You shall rise up before the gray headed, and honor the aged". The New Testament likewise promotes an attitude of honor as it reiterates the command to honor parents in particular (Matt. 15:1-9; Eph. 6:2, 3) and the elderly in general (I Tim, 5:1-3).

The Lord loves the elderly. Upon them God bestowed many of His greatest responsibilities. In various dispensations He has guided His people through prophets who were in their advancing years. He has needed the wisdom and experience of age, the inspired direction from those with long years of proven faithfulness to His gospel.

The Lord blessed Sarah, in her old age, to bear Abraham a child. Perhaps King Benjamin's greatest sermon was given when he was very elderly and nigh unto death. He was truly an instrument in the hands of the Lord as he was able to lead and establish peace among his people.

Many other men and women throughout the ages have accomplished great things as they went forth to serve the Lord and His children, even in their elderly years.

In our dispensation, of the thirteen prophets who have been called of the Lord, many were called when they were in their seventies or eighties, or even older. How the Lord knows and loves His children who have given so much through their years of experience!

We love you who are the elderly in the Church. You are the fastest-growing segment of our population in the world today, as well as within the Church.

Our desires are that your golden years will be wonderful and rewarding. We pray that you will feel the joy of a life well-spent and one filled with fond memories and even greater expectations through Christ's atonement. We hope you will feel of the peace the Lord promised those who continue to strive to keep His commandments and follow His example.

We hope your days are filled with things to do and ways in which you can render service to others who are not as fortunate as you. Older almost always means better, for your wealth of wisdom and experience can continue to expand and increase as you reach out to others.

CHAPTER 5 MAKING THE MOST OF THE SENIOR YEARS

Programs and Activities

1. Work in the church and attend often: The elderly should use their energies not only to bless their predecessors, but to ensure that, insofar as possible, all of their posterity might receive the ordinances of exaltation in the church. Work with their families; counsel with and pray for those who may yet be unwilling to prepare themselves.

Urge all who can to attend church frequently and accept calls to serve in the church when health and strength and distance will permit. With the increasing number of churches, more members are needed to prepare others for service.

2. Collect and write family histories: Gather and write personal and family histories. In so many instances, one alone may have within them the history, the memory of loved ones, the dates and events. In some situations they are the family history. In few ways will their heritage be better preserved than by collecting and writing their own histories.

3. Become involved in missionary service: even a “local” missionary service. The need is increasing for senior missionaries.

4. Have the elderly provide leadership by building family togetherness: Have them urge other senior members, when possible, to call their families together, make phone calls, write letters or send cards. Organize them into cohesive units or teams.

Have someone gather birthday, wedding anniversary, births, deaths, special events for each other’s family members. It can be used as reminders for one particular person or many persons.

Have the teams gather address information and then have them make hand- made cards, etc to help each other stay in contact with family members.

Establish family reunions where fellowship and family heritage can be felt and learned. Some of the sweetest memories are formed through family reunions and gatherings which will bind you together eternally. In doing so, we can will create a bit of heaven right here on earth within individual families. After all, eternity will be but an extension of righteous family life.

5. Accept and fulfill Church callings: We trust that all senior members who possibly can will accept callings in the Church and fulfill them with dignity. We all need to hear the successes and failures and how an elderly person has risen above heartache, pain, or disappointment, having become stronger for experiencing them.

There are rich opportunities for the elderly to serve in most of the organizations of the Church. Most elderly people have the time and solid gospel foundation which enable them to render a great work. In so many ways they lead out in faithful service in the Church.

7. Render Christ like service: Christ like service exalts. Call upon the senior members who are able to thrust in their service to others. This can be part of the sanctifying process. The Lord has promised that those who lose their lives serving others will find themselves. Peace, joy and blessings will follow those who render service to others. Yes, we commend Christ like service to all, but it is especially sweet in the lives of the elderly.

8. Help the elderly stay physically fit, healthy, and active: Set out with a walking program for those that are able, in the early mornings or encourage an exercise program with exercise equipment. Others have swimming programs to keep them fit. Through keeping active, both the mind and the body function better.

PASTORAL SUPPORT ISSUES

LOSS OF SPOUSE

For those who have lost spouses, there is sometimes a feeling of uselessness and aloneness which can be extremely overwhelming. In addition to the suggestions just mentioned, here is a sampling of activities that have proved helpful to others.

Some who are alone keep busy by quilting blankets for each new grandchild to be married or each new baby born into the family. Others write letters on birthdays or attend school and athletic events of grandchildren when they can and some compile albums of pictures of each grandchild to give on birthdays.

The key to overcoming aloneness and a feeling of uselessness for one who is physically able is to step outside by helping others who are truly needy. For those who render this kind of service in some measure will be healed of the loss of loved ones or the dread of being alone. "The way to feel better about your own situation is to improve someone else's circumstances".

Scripture from Psalms: "Cast me not off in the time of old age; forsake me not when my strength faileth." (Ps. 71:9.) We encourage families to give their elderly parents and grandparents the love, care, and attention they deserve. Scriptural commands that we must care for those of our own house lest we be found "worse than an infidel." (1 Tim. 5:8.)

Parents and grandparents are our responsibility, and we are to care for them to the very best of our ability. When the elderly have no families to care for them, Churches, Pastoral Clergy members and Society leaders should make every effort to meet their needs in the same loving way. We submit a few suggestions to families of the elderly.

Ever since the Lord etched the Ten Commandments into the tablets of stone, His words from Sinai have echoed down through the centuries to "honor thy father and thy mother." (Ex. 20:12.)

To honor and respect our parents means that we have a high regard for them. We love and appreciate them and are concerned about their happiness and well-being. We treat them with courtesy and thoughtful consideration. We seek to understand their point of view. Certainly obedience to parents' righteous desires and wishes is a part of honoring.

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Furthermore, our parents deserve our honor and respect for giving us life itself. Beyond this they almost always made countless sacrifices as they cared for and nurtured us through our infancy and childhood, provided us with the necessities of life, and nursed us through physical illnesses and the emotional stresses of growing up.

In many instances, they provided us with the opportunity to receive an education, and, in a measure, they educated us. Much of what we know and do, we learned from their example. We learn to be forgiving of our parents, who, perhaps having made mistakes as they reared us, almost always did the best they knew how.

Even when parents become elderly, we ought to honor them by allowing them freedom of choice and the opportunity for independence as long as possible. It is unnecessary in most cases to take away from them choices which they can still make. Some parents are able to live and care for themselves well into their advancing years and would prefer to do so. When they can, let them.

If they become less able to live independently, then family, Church, and community resources may be needed to help them. When the elderly become unable to care for themselves, even with supplemental aid, care can be provided in the home of a family member when possible. Church and community resources may also be available in this situation.

The role of the care-giver is vital. There is great need for support and help to be given to such a person. Usually this is an elderly spouse or a middle-aged daughter with children of her own to care for as well as caring for the elderly parent.

Grandparents can have a profound influence on their grandchildren. Their time is generally not as encumbered and busy as the parents', so books can be opened and read, stories can be told, and application of gospel principles taught.

Children then obtain a perspective of life which not only is rewarding but can bring them security, peace, and strength. It is possible to send letters, tapes, and pictures, particularly where distances are great and it is not possible to see one another often.

Those who are blessed with closeness to grandparents and other elderly people have a rich companionship and association. There might be times when they can attend graduations, weddings, temple excursions, missionary farewells and homecomings, and other special events with family members.

Elderly people enjoy watching children and grandchildren grow and achieve in special ways, as they are able to share in many of their joys and victories. Happiness blesses our lives as our children strive and achieve in their own lives. In 3 Jn. 1:4 we read, "I have no greater joy than to hear that my children walk in truth." And knowing this can bring a renewal of love and courage to continue in our own struggles.

Finally, we would urge Christians and members of the clergy to be sensitive to the Spirit of our Father in Heaven in assessing and meeting the spiritual, physical, emotional, and financial needs of the elderly.

Great comfort and peace can come to those who know they have someone to whom they can turn in time of emergency or need. It is important that tact, diplomacy, and sincerity be evident in assessing and addressing such needs.

The independent elderly can also be involved in compassionate service assignments. Include them also in stake and ward social activities, especially single members and those with dependent spouses. So many times they are forgotten. Especially at the time of the death of a spouse, loving care can be given. This is a very tender time for most.

At times temporary relief is very much needed and appreciated by family members who provide constant physical and emotional care to those with special needs. It is important to help the family maintain its functions as a family with periodic freedom from the heavy responsibilities that long-term or terminal illness can impose. All need loving support and relief from the overwhelming duties of serious illness or problems.

The Savior lives. This is His church. The work is true, and in the words of our Lord and Savior, “Look unto me, and endure to the end, and ye shall live; for unto him that endureth to the end will I give eternal life” (3 Ne. 15:9), to which I testify in the name of Jesus Christ, amen.

This brief exploration of the world of the third and fourth stages has thrown light on many problems associated with old age, which demand specific responses from civil society and special attention from the church community. But it has also revealed the richness in humanity and wisdom of older people, who still have a great deal to offer to the Church and to society.

To accompany older people, to approach them and enter into relationship with them, is the duty of us all. The time has come to begin working towards an effective change in attitude towards older people and to restore to them their rightful place in the human community.

Society and its institutions are called to give older people scope for personal development and participation, and provide them with forms of social assistance and health-care consonant with their needs and responding to the need of the human person to live with dignity, in justice and freedom.

To this end, alongside the commitment of the State aimed at promoting and safeguarding the common good, the involvement of the volunteer services and the contribution of initiatives inspired by Christian community need to be supported and fostered, in full respect for the principle of subsidiary.

The Christian community must strive to help older persons to live their own life in the light of the faith and to rediscover in it the value of the resources that they are still able, and still have a responsibility, to place at the service of others.

Older people must become increasingly conscious that they have a future before them that they themselves must shape.

They still have a responsibility to testify to children, young people, adults and those in their own age group that there is no meaning or joy outside the bond with Christ, neither in their own personal lives not in their relations with others.

“The harvest is rich” (Mt 9:37). These words of the Lord are particularly applicable to the field of the pastoral care of older people. It is a field so extensive as to require the generous work and passionate commitment of countless apostles, workers and witnesses who can testify convincingly to the fullness of life that can characterize this season of life if it be founded on the “rock” that is Christ (Mt 7:24-27).

Service to older people, especially if accompanied by a pastoral care alert to the diversity of needs, open to everyone's participation, and aimed at exploiting everyone's capacities, represents an enrichment for the whole Church. It is therefore desirable that as many as possible embrace this service grasp its profound significance as a process of conversion of heart and reciprocal giving between the generations.

The year 1999, dedicated to older people by the United Nations, is also the year dedicated to God the Father as part of the preparation for the Great Jubilee of the year 2000: a providential coincidence, which can provide the younger generations with an occasion to reflect on and reestablish their relations with the older generations.

It can also provide those who are no longer young with an occasion to re-examine their own existence and to place it in the joyful perspective of bearing witness that “the whole of the Christian life is like a great pilgrimage to the house of the Father, whose unconditional love for every human creature we discover anew each day”.

In the year 2000, the Jubilee Year which introduces the People of God to the third millennium of the Christian era, a special day, September 17th, will be dedicated to older people. We are confident that they will not overlook this important date.

We are also confident that the prospect of the Great Jubilee will inspire initiatives at the local, national and international level that will permit older people to express ever more strongly and in ever growing numbers their capacity to participate, to give hope and to receive hope. For only with older people, and thanks to them, shall the praises of the Lord be joyfully sung forever and ever (Ps 79:13).

(1) The “population” section of the United Nations' Department of Economic and Social Affairs published new demographic estimates and projections on 26 October 1998. The chapter devoted to the growth in the number of older people suggests, inter alia, that the 66 million octogenarians and over-80 year-olds in the world today are destined to increase to 370 million in 2050, including an estimated 2.2 million centenarians.

(2) The most recent studies of the United Nations are continuously adjusting downwards the forecasts for population growth in the next few decades. The United Nations Population Fund, in its report on the state of the world population for 1998, confirms the demographic downturn.

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Only in a limited number of African countries does the birth rate remain high. Elsewhere, from Asia to Latin America, the birth rate is constantly decreasing.

(3) The application of these principles, the fifth revision of the International Plan of Action, and the revision of the strategy adopted by the General Assembly of the United Nations in 1992, constitute the “Global Objectives Relating to Ageing for the Year 2001”.

(Provided Courtesy of: Eternal Word Television Network 5817 Old Leeds Road Irondale, AL 35210)

NOTES

CHAPTER 6 WHAT IS A NURSING CARE FACILITY?

Definition: Nursing Homes

A term used to refer to care facilities. There are many different names that are used when referring to a nursing home: Below are a few examples:

- Skilled Nursing Facility
- Intermediate Care Facility
- Assisted Living Homes
- Adult Family Homes
- Adult Day-Health Care Center
- Multi-Level Care Complexes
- Nursing Care Facility
- Convalescent Centers

A nursing home is a residence that provides necessities such as room, meals, activities, medical, physical and psychological services and help with daily living and protective supervision to residences.

Nursing home residents are not all just elderly. Some residents have physical and mental impairments which keep them from living in the outside world and nursing homes can provide several levels of care from custodial to skilled nursing.

Convalescent homes: are normally used in reference to a long-term nursing facility which provides care 24/7 with assistance of professional nurses and physicians.

Rehabilitation Center: refers to short-term care for patients involved in accidents or illnesses.

Skilled Nursing Facilities: are facilities that provide round the clock care. Many of the patients are completely or partially confined to their beds and are often incontinent with a registered nurse attending 24 hours a day 7 days a week. Patients who suffer from Alzheimer's disease and dementia are often placed in a skilled nursing facility.

Intermediate Care Facility: residents can usually get out of bed, with or without assistance and require intermittent care. Some Alzheimer's patients can be placed in intermediate care facilities depending on the level of the disease they suffer from.

Assisted living facilities: will provide full-time, long term care for persons who do not require a full care nursing facility and who need assistance with medications, bathing, dressing and meals.

Assisted Living Facilities differ from nursing homes because the residents are required to have a higher level of functionality (for example, they have to be able to feed and bathe themselves).

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Retirement Communities: These facilities offer retired and elderly individuals the option of living in a community with other seniors in an independent atmosphere. These residents are offered social activities, meals, transportation and assistance for shopping and medical needs. Most of these facilities offer assisted living quarters also on the premises.

Adult Family Homes: or sometimes referred to as “Residential Care Facilities” or “Adult Care Residences”. Usually a facility who cares for mentally or physically challenged persons. Residents may be able to move around on their own or in wheel chairs and are supplied room and board as well as supervision and assistance with daily activities such as bathing, dressing or meals. The program is designed to assist residents in independent living with assistance. These facilities are staffed around the clock.

Adult Day-Health Care Centers: These facilities are open weekdays, day time only for seniors and disabled persons who generally live with relatives during non working hours. Activities are provided throughout the day. Snacks and lunch are provided. Each facility differs with their programs but some may provide nursing and rehabilitation.

Multi-Level Care Facilities: These facilities offer independent and retirement living options. Services include medical and nursing services for aging disabilities and offer activities for the residents.

Nursing homes and care facilities represent the fundamental link in the continuum of long-term or short term care. Their job is to provide 24-hour nursing care to those who are chronically ill or injured, have health care needs as well as personal needs and are unable to function independently.

A nursing home is about more than medical care. It’s a place where patients can go on with their lives – and even engage in many activities they may have never taken part in before – while under the secure and capable watch of a team of trained caregivers.

HOW THEY DIFFER

Some residents spend only a short time in a Nursing Home; others spend the rest of their lives there. However, the Nursing Home population has been declining in recent years as more choices become available for seniors who need help.

With the rise of Assisted Living Facilities, for example, people who might formerly have gone into a Nursing Home yet are able to manage with more limited care, now have an additional option.

Assisted living facilities offer help with activities of daily living (personal or custodial care), but are very limited, medical care. An Assisted living facility also places greater emphasis on personal privacy and autonomy than does a nursing home.

Nursing homes have RN’s onsite and MD’s on call, 24 hours a day; while assisted living facilities provide only personal assistance that can be performed by someone with little or no medical training.

Retirement communities provide independent living, housing-with-services, and Nursing home care in one location, enabling seniors to remain in a familiar setting as they grow older. Many seniors enter a retirement communities while they are healthy and active, knowing they will be able to stay in the same community and receive Nursing home care should this become necessary.

If a senior requires nursing home care for a while and then becomes well enough to again live independently, they often are moved back to an independent living arrangement without leaving the retirement community.

CANDIDATES FOR SKILLED NURSING FACILITY

Each elderly person's need for care or assistance is unique. Some individuals may have a short-term need, perhaps caused by a fall and a broken hip, which necessitates a brief hospitalization followed by rehabilitation.

After a one or two month nursing home stay, the senior may be able to return home and continue receiving some services such as physical therapy from a home health care agency, if necessary.

Other people have more long-term needs, possibly due to Alzheimer's, extreme frailty, or a stroke. In this case, care is necessary on an ongoing basis.

A Skilled Nursing Facility is for an individual who meets the following criteria:

- Cannot take care of themselves because of physical, emotional, or mental problems;
- Can no longer care for their own personal needs, such as eating, bathing, using the toilet, moving around, or taking medications (custodial care);
- Requires more care than can be provided by their caregiver, and cannot live alone;
- Might wander away if unsupervised;
- Has extensive medical needs requiring daily attention or monitoring by an RN supervised by an MD;
- Is going to be discharged from the hospital and requires temporary Skilled Nursing care or rehabilitation before returning home or to a residential facility;
- Has been recommended for a Nursing Home by a physician.

SKILLED NURSING FACILITIES

Skilled Nursing Facilities provide a private or shared room with a private or shared bathroom. Some Nursing Homes allow couples to stay together, and some may even allow pets. With the emphasis on patient care, however, the general ambiance has precluded much privacy or a sense of "home".

Increasingly, however, creative architectural design has made some Nursing Home living arrangements more homelike. Through the use of natural fibers and lighting, for example, many spaces throughout the Nursing Home feel friendly and warm.

Many resident rooms and hallways may be carpeted, with new carpet material that can be easily cleaned on a daily basis. In addition, outdoor courtyards and indoor plants enhance livability and personal comfort in some of today's Nursing Homes.

Another major design change that's beginning to appear is in nurse's stations. Formerly centralized for efficiency, a Skilled Nursing Facility nurse's station can now be more like a reception area where residents and staff can easily interact.

SERVICES PROVIDED BY A NURSING HOME/SKILLED NURSING FACILITY

Nursing Homes/Skilled Nursing Facilities offer an array of services, in addition to the basic skilled nursing care and the custodial care. They provide a room, all meals, some social activities, personal care, 24-hour nursing supervision and access to medical services when needed.

Basic Nursing Home Services generally include:

- A clean, furnished room (private or shared)
- Dietary services: nutritious meals and snacks, in accordance with medical requirements
- Housekeeping and linen service
- Personal (custodial) care (including incontinence care)
- Therapeutic recreation and activities
- Transportation (some)
- 24-hour onsite medical staff: registered nurses (RNs), licensed practical nurses/licensed vocational nurses (LPNs/LVNs), and nurses' aides
- Supervision by physicians, some of whom are on call to consult with staff and visit patients as needed
- Resident evaluation and care planning

For an additional fee, many Nursing Homes provide:

- Rehabilitation services: occupational, physical, respiratory and speech therapy
- Pharmacy, laboratory and radiology services
- Dental services
- Special care units (see next section)
- Personal care items
- Laundry service

SPECIALTY CARE PROVIDED BY THESE FACILITIES MAY INCLUDE

- Alzheimer's treatment
- Cancer
- Cardiovascular disease
- Developmentally disabled
- Dementia
- Head trauma
- Hematologic conditions
- Mental disease
- Neurological diseases
- Neuromuscular diseases
- Orthopedic rehabilitation
- Pain therapy
- Pulmonary disease
- Para/quadruplegic impairments
- Stroke recovery
- Trauma
- Wound care

PROFESSIONAL CAREGIVERS

For every patient, nursing homes and care facilities have a single mission: to enhance the abilities rather than the disabilities of that individual while providing comprehensive care that upholds his quality of life. To accomplish this, each staff member, from the maintenance supervisor to the bookkeeper, must work as a team to see that high standards are met.

Here are some descriptions of the trained and experienced professionals you'll find at every nursing care facility:

Administrator: Administrators are responsible for facility operations as well as compliance with regulations.

Medical Director: Medical directors can work full time or as consultants. They work in cooperation with each patient's individual physician to oversee implementation of a care plan.

Licensed Practical Nurses: (LPN) and Registered Nurses (RN) – State and federal regulations help determine the number of registered nurses (RN), licensed practical nurses (LPN) and CNAs on staff at nursing facilities at any given time. The nursing staff is supervised by an RN who serves as director of nursing (DON). Long-term care nurses are tested and licensed just as nurses working in hospitals and physicians' offices are.

Certified Nursing Assistants: (CNA) – CNAs have the most interactions with patients. One way to understand the role of CNAs is by referring to activities of daily living (ADL), such as bathing, dressing, toileting, eating and transferring (from a wheelchair, bed or chair). The average nursing facility patient needs assistance with at least four of the five ADLs.

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Dietary Supervisor: A dietary supervisor manages the daily operations of the food services department, in conjunction with a registered dietitian who either is on staff or serves as a regular consultant. Therapeutic diets ordered by physicians must be followed, but dietary staffs try to incorporate patients' individual tastes as much as possible in planning menus.

Activity Coordinators: Activity coordinators provide non-medical care that is essential to patients' overall well-being and satisfaction. Activity plans are developed to include meaningful activities that reflect patients' interests and lifestyle.

Social Service Worker: A social service worker's role is to serve as a counselor to patients and families, easing their adjustment to nursing care facility life. Social service workers are essential to the admissions process when emotional, social and financial difficulties sometimes arise. Social service workers assist patients and families in identifying and obtaining services available to them.

Environmental Service Workers: Environmental service workers maintain a clean, safe environment for patient care while making sure proper improvements are made to the facility.

SPECIAL SERVICES

The staff of professional caregivers described provides care that is available at most nursing facilities. In addition, the typical facility has a number of other professionals who provide patient services, some may include:

- Dental care
- Eye care
- Laboratory procedures
- Mental health care
- Occupational therapy
- Physical therapy
- Podiatry care
- Speech therapy
- Radiology
- Respiratory therapy

RESIDENT-ORIENTED CARE Resident oriented care is where nurses are assigned to particular patients and have the ability to develop relationships with individual patients. Patients are treated more as family, as opposed to random patients. Using resident-oriented care, nurses are able to become familiar with each patient and cater more to their specific needs, whether they are emotional or medical.

Residents who receive resident-oriented care experience a higher quality of life, in respect to attention and time spent with patients and the number of fault reports after the introduction of Primary Nursing.

Although resident-oriented nursing does not lengthen life, nursing home residents are able to connect with someone, which allows them to dispel many feelings of loneliness and discontent.

RESIDENT ASSIGNMENT

Resident assignment refers to the extent to which residents are allocated to the same nurse. With this particular system one person is responsible for the entire admission period of the resident. However, this system can cause difficulties for the nurse or care-giver should one of the residents they are assigned to pass away or move to a different facility, as the nurse/caregiver may become attached to the resident(s) they are caring for.

In coming to this conclusion three guidelines must be assessed:

- Structure
- Process
- Outcome

Structure is the assessment of the instrumentalities of care and their organization; Process being the quality of the way in which care is given; Outcome being usually specified in terms of health, well-being, patient satisfaction, etc. Using this criteria find that they are strengthened when residents experience resident oriented care.

Communication is also heightened when residents feel comfortable discussing various issues with someone who is experienced with their particular case. In this particular situation nurses are also better able to do longitudinal follow up, which insures the implementation of more lasting results.

Various findings suggest that task-oriented care produces less satisfied residents. In many cases, residents are disoriented and unsure of whom to disclose information to and as a result decide not to share information at all.

Patients usually complain of loneliness and feelings of displacement.

"Resident assignment" is allocated to numerous nurses as opposed to one person carrying the responsibility of one resident.

Because the load on one nurse can become so great, various nurses are unable to identify with gradual emotional and physical changes experienced by one particular resident.

A nursing home is a place for people who don't need to be in a hospital but can't be cared for at home. Most nursing homes have nursing aides and skilled nurses on hand 24 hours a day.

Some nursing homes are set up like a hospital. The staff provides medical care, as well as physical, speech and occupational therapy. There might be a nurses' station on each floor.

Other nursing homes try to be more like home. They try to have a neighborhood feel. Often, they don't have a fixed day-to-day schedule, and kitchens might be open to residents. Staff members are encouraged to develop relationships with residents.

Some nursing homes have special care units for people with serious memory problems such as Alzheimer's disease. Some will let couples live together. Nursing homes are not only for the elderly, but for anyone who requires 24-hour care.

Nursing home facilities offer custodial or personal care that includes assistance with what are known as the activities of daily living, such as:

- Bathing
- Dressing
- Eating
- Grooming
- Getting in and out of bed, or walking around
- Toileting (incontinence care)

People who are able to recover from a disabling injury or illness, may temporarily need the custodial care as they are getting back the strength and balance to be independent again. For people who are losing their ability to function independently due to chronic disease and increasing frailty, custodial care may be a long-term need.

In the most severe cases where a person is bed-bound, ongoing supervision by an RN is necessary along with the custodial care, to ensure proper hydration and nutrition and to prevent skin breakdown. If a custodial care resident becomes ill or injured, they may spend a period of time in skilled care, and then return to custodial care.

Nursing Homes/Skilled Nursing Facilities offer an array of services, in addition to the basic skilled nursing care and the custodial care. They provide a room, all meals, some social activities, personal care, 24-hour nursing supervision and access to medical services when needed.

POPULATION TRENDS

The number of people admitted to nursing homes in the United States has increased since 1994. Most people are admitted to nursing homes after being discharged from a hospital after surgery or a sudden illness. Unfortunately, nursing-home residents also often return to the hospital with sudden medical illness.

Without a breakthrough in the treatment of dementia, the number of people 65 and older living in nursing homes will likely double by the year 2020. Interestingly, the occupancy rates in nursing homes have gone down over the past several years, so that the average nursing home is less than 90% full. Generally, this is thought to be because there are other options for long-term care, such as assisted living facilities.

There are currently approximately 1.6 million people in nursing home care facilities in the country today and that number is growing. (Michael Monheit, Attorney at Law, Rydel PA.)

NOTES

CHAPTER 7 THE NURSING HOME CHAPLAIN

A volunteer chaplain who enters into a nursing home ministry is someone dedicated to spiritually encouraging residents and forming true lifetime friendships with residents and to spiritually enrich the lives of those who are isolated from the rest of the world. The nursing home chaplain is a service based on respect for the elderly and disabled persons in these facilities.

Many nursing care residents have no one who visits them on a regular basis for many reasons and some are the following:

- Distance
- Age
- Disabilities
- No living next of kin
- Busy life styles
- Lack of interest in the elderly

And unfortunately the lack of interest for the elderly is the #1 reason for residents not getting visitors.

Many nursing homes are short staffed and employees work very hard just meeting basic health needs of residents. According to a recent National Nursing Home Survey, 94% percent of residents require help with bathing, 87% need help dressing, and over half need bathroom assistance.

Loss of dignity, hope, and connection with the outside world remain a very real part of nursing home life. Nursing home chaplains attempt to restore dignity, and alleviate this pervasive sense of loneliness, by committing to be a Friend to a resident in need.

Chaplains build individual relationships with their assigned residents, through activities or just being there to talk. Often time's volunteer chaplains may be assigned residents and are asked to make an initial commitment to the weekly visits they make, of at least one hour each.

Uncomfortable sights, sounds, and smells in long-term care facilities can often overwhelm the new volunteer chaplain. It helps volunteers to overcome their fears and insecurities by assigning each new volunteer an experienced mentor to accompany them on at least their first two or three visits. It is important that the experienced Chaplain stay in touch with new volunteers to support one another, and so that a volunteer coordinator is available should any problems arise.

Nursing homes usually accept of all faith backgrounds and chaplains try to reach out to all residents, regardless of their religion.

If you are attempting to start a nursing home ministry, there are very important principles that you must follow:

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- 1) **No proselytizing**: No chaplain should pressure any nursing home resident, any other volunteer, or any nursing home staff to convert to their faith or to embrace their doctrine.
- 2) **Accept volunteers of any faith background**: All chaplains should be open to accepting volunteers of any faith group, including (but not limited to) Buddhist, Catholic, Eastern Orthodox, Hindu, Islamic, Jewish, and Protestant. They should also welcome those who belong to no particular faith group.
- 3) **Reach out to nursing home residents of any faith background**: Likewise, chaplains should try to reach out to all nursing residents in need of a friend, regardless of their faith background.

Many chaplains are motivated to volunteer based on their faith, however, all faith groups and backgrounds should feel welcome. Chaplains should reach out to residents of all backgrounds, it should be considered to be inappropriate for any chaplain to pressure a resident to convert to their particular faith.

Faith sharing between residents and the chaplain is a wonderful thing, and many residents enjoy activities such as reading the bible, singing faith-based songs, prayer or just casual “religious or spiritual conversations” with volunteer chaplains and other residents. It is considered acceptable, as long as no one feels pressured to participate in such activities against their will. There is a difference between proselytizing and faith sharing.

The purpose of a nursing home chaplain is to form friendships with residents provide spiritual guidance and offer a support system but there are certain limits to the chaplain’s role, which is important to adhere to.

- 1) Chaplains **DO NOT** get involved in the medical care of the residents. Chaplains are not trained to do things such as helping residents in and out of bed, dressing, or administer medication, etc.
- 2) Maintain confidentiality at all times. Volunteer Chaplains must abide by all confidentiality policies concerning the residents where medication, doctors or care is concerned.

This may become a difficult task. When a chaplain develops a relationship with the residents, they begin to care for them deeply, and want to make sure they are getting the best care or treatment. Unfortunately, this type of information is not appropriate for a chaplain to pursue, and chaplains must focus on interpersonal needs of the residents instead.

Nursing home care is a growing and thriving industry. The need for a nursing home chaplain is a natural. The administration, employees and residents, and Residents' families at a nursing home facility experience frustrations, grief and pain daily.

Volunteer chaplains will help meet these needs. A bridge between the local church and the senior adult care facility can be established through a nursing home chaplain. The steps for implementing this ministry are as follows:

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1. Schedule a meeting with the administrator of the nursing home.
2. Determine what needs are not presently being met
3. Plan with the administrator the programs which a chaplain could implement.
4. Recruit a chaplain and volunteers for the programs selected.
5. Set a starting time for the ministry to start.
6. Follow up the meeting with a letter outlining what was agreed upon.
7. Implement the ministry.
8. Evaluate every six months.

A variety of ministries may be implemented in the nursing home setting. The most obvious are visitation and counseling. Several other ideas are offered here which go beyond these important services.

Worship Services: The chaplain may be responsible for leading a weekly church or prayer service or for recruiting area churches to lead service. These worship experiences are usually traditional in nature lasting thirty or forty-five minutes.

The worship time should be scheduled to fit into the facilities calendar of events which will most likely not be at 11:00 a.m. The chaplain will need to promote the service encouraging residents and staff to attend but not “pushing” them to do so.

Worship of God often is neglected in the lives of the elderly residents of nursing homes. Yet worship can and should be an important part on their lives. Not only can it offer God the praise and honor he deserves, but it can bring deep satisfaction, joy and peace.

Because of the varied backgrounds of people in nursing homes, there are many types of worship that can be appropriate:

First Type:

- Formal liturgical services
- Informal
- Flexible
- Improvised

Second Type:

- In homes for limited alertness
- For the disabled
- For Alzheimer’s patients
- For the mentally challenged

In either situation there is likely to be a variety of religious backgrounds: such as:

- Roman Catholic
- Baptist

- Presbyterian
- Church of Christ
- Jewish
- Methodist
- Lutheran- And many other religions.

There are many different ethnic backgrounds in nursing homes. Some blend of traditions is highly recommended, a variety of hymns and style of prayer, or something familiar that people can relate to their own past experience. Tell Bible stories, old hymns, the Lord's Prayer, the doxology. Focus on the basics of Jesus and Christianity, Jesus' death and resurrection and new life. Avoid unnecessary controversy.

INITIATING THE WORSHIP SERVICE

Designate the time, date, and place by consulting the activity director and nursing staff. Do not interrupt meals, medication times or planned activities, or visiting days. Allow time before services and assist gathering residents from their rooms and for reminding people to come and bring those in wheelchairs. Consider visiting rooms regularly before the service to extend personal invitations.

Make sure the location is easy to get to and the room will hold the amount of people you expect to attend. If you do use a general area such as a lounge be considerate and tactful as you turn off the television, rearrange furniture as necessary and otherwise transform a lounge into a chapel. Be gentle and humble in your approach and don't let negative reactions deter you from your purpose. If necessary, find another location.

Move around during the service to assure that you are seen and heard by all participants. Move slowly and don't be surprised by someone wanting to touch you as you pass. Try to minister to this need in a way that doesn't detract from the service. A touch of a hand or a brief word of acknowledgment is usually enough.

The chaplain and all those involved must be sensitive to those who are hard of hearing. It is not appropriate to ask if anyone is hard of hearing or is having problems hearing. Once you have determined what your volume level should be, maintain it.

SUGGESTED FORM OF WOSHIP

(Total time: 30 – 45 minutes)

- Call to worship
- Songs
- Scripture
- Message
- The Lord's Prayer
- Songs
- Closing

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Announce at the beginning of the service that you are willing to talk and pray with individuals after the service. Those who have a desire to share needs and deep felt emotions during the service will then be satisfied to wait. Some elderly may wish to have communion. The elderly are often overlooked in this area of their spiritual life.

Arrange to visit during the week before hand to find out how many desire communion. Be sure to write down names and go to the individual rooms to minister to provide a link with the worship services. If a minister or pastor from another church is requested for private Holy Communion, make arrangements for the minister or pastor to attend.

PARTICIPATION

Participation by persons other than the chaplain is very important. Since the elderly often are like small children with respect to attention span, interest, and activity during the service they may also help to promote alertness and attention. This is especially true whether the activity comes from people you bring with you, or from those within the home. Beware however, of precipitating confusion and disorder through too much activity or by means of changes that occur too quickly.

Participation by people from outside: Gifts such as prayer, music, testimony or scripture reading are all God given gifts. Assistant chaplains and volunteers are an invaluable part of a worship service in a nursing home and they also act as troubleshooters and peace makers with the residents. Children can also be of considerable help on certain tasks and usually are appreciated by the residents.

Participation by residents in the nursing home: Feel free to ask staff, residents and even visitors to participate if they wish. Often there are staff members who are free to listen, join in and help out if needed.

Give the residents that are able the opportunity to contribute to the service. Take care however, to consider certain contributing factors when allowing a story or a personal concern such as “I want to die” or “someone stole my money” or “I hate it here”. Ask yourself the significant impact that such a conversation may add or distract from the service.

Participation from the residents is valuable. Their worship is a great blessing. It is important to bring them into the service as much as possible. But as you do, be ready to handle the problems that may arise.

INTERRUPTIONS DURING THE SERVICE

In any worship service there is going to be interruptions. Many factors may cause this:

Wandering visitors, talking, and shouting, arguing residents and staff are among those attending the worship service may cause unnecessary interruptions. You must recognize the interruption within the context of worship and ignore it.

Often a few soft, direct words along with a light touch on the hand or shoulder will restore calm. If a staff member is noisy, inconsiderate or disruptive wait until after the service and kindly tell

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the staff members how much their corporation would be appreciated. Most staff members are willing to cooperate if they are approached in a humble manner. If problems persist feel free to speak to the activity director or the head nurse in charge.

Visitor interruptions: Most visitors are sensitive and cooperative. Encourage them to join in the worship service until it is finished and then continue their visit. If they have limited time and must visit with their friend or relative, assist them in moving away from the service.

PREPARING THE MESSAGE

Below are suggestions to those who are not accustomed to delivering a Bible message as well as to those who might want to improve their skills:

1. Familiarize yourself with the Scripture passage that you are going to base your message on. Read and re-read the passage in its larger context. Pray for insight to understand and present the passage faithfully. If possible, memorize the key text.
2. Select several key words or concepts from the passage and study them in light of the whole of scripture. In studying Matthew 5:6 for example: took at the image of hungering and thirsting, as well as being satisfied, in both the Old and New Testaments. Explore the concepts of blessedness and righteousness.
3. Summarize the point of the passage in a simple sentence. It is important, to be clear and concise. Making such a summary will help you to do this. An example of such a sentence, using Matthew 5:6 as a base. In order to be righteous we must desire it with a whole heart.
4. Prayerfully seek out applications of this passage to present daily situations in your life and the lives of the elderly. Reformulate your summary sentence with these applications in mind. Using the word so that you audience will be clear on what they can do differently in response to your preaching.
5. As you actually write the message, work backwards from your conclusion. Ask yourself questions like what, where, how and why about the applications, in order that all you say will point to your single conclusion.

GUIDELINES FOR BIBLE MESSAGES:

- Relate to the past
- Use a scripture basis
- Review and evaluate past relationships with God
- Specify general areas for understanding
- Relate to the present
- Reflect on past conflicts and resolutions
- Reflect on present situations
- Speak of specific concerns

- Relate to future hopes
- Emphasize on the promises of God
- Centralize on the resurrection of the Lord
- Exhort the congregation to hope, love and service to God
- Use vivid illustrations to clarify main points
- Make sure images are something the elderly can relate to
- Share illustrations from your own life's experiences
- Repeat and simplify messages.
- Elaborate, amplify, explain, illustrate, repeat and dwell upon the main text of the message

BIBLE STUDIES FOR THE ELDERLY

This outline will help you discover what Scripture says concerning the elderly, their role and the responsibility we have to minister to them and to get you in touch with the relevant passages of Scripture.

What the Chaplain or clergy does depends on them. Spend time in the scripture. Memorize these passages and share them with people you meet in your ministry:

Biblical view of aging

Zech. 8: 3-5, Jer. 31:13, Old age is a reward for piety

Deut. 30-19-30, Loving obedience to God is rewarded with long life

Ex. 20:12, Honor to father and mother results in long life

Job.42:16, 17, Job's perseverance was rewarded with long life

Divine favor

Gen. 15:13-15, Abraham is assured of God's blessing of old age

Ps. 128:5-6. To live to see one's grandchildren is a blessing of God

1 Sam. 2:31, 32. Lack of age implies a curse

Old age is not always a blessing

Deut. 28:50, God curses those who do not obey him, this curse bears on the elderly

Is. 3:5; 9:14,15 Jer, 51:22. God is no respecter of persons in his chastisement and punishment

Old age is honored and respected

Lev. 19:32 you shall rise up before gray headed, honor old age and you shall revere your God.

Honor of Old age in the New Testament

1 Tim. 5:1-2. the old are to be treated with the same honor due to our parents

1 Pet. 5:5. The younger are to be subject to the elder

Further study on the honor due parents

Ex. 20:12, Lev. 19:3, Deut. 5:16; Eph. 6:1-3, Matt. 15:1-9; Mark. 7:6:12.

The honor of old age recognized as a new beauty

Prov. 20:29; 16:31 God's covenant promises are given to the elderly

Is. 46:3-4. God's faithfulness is constant, manifested as compassionate care to elderly saints
Ps. 71. The righteous man prays to God in his old age,
Ps. 103:5. God renews the youth of his people
John. 3:4-8. God can give new life even to the elderly
Ps. 92:14, 15. God promises fruitfulness to the elderly
Ps. 146:5-9, 146:3, 6; Jas. 1:27. Widows are a privileged class for God's care and provides a model for our care of the elderly
Ps. 68:5. God protects the widow
Deut. 10:18, 27:19; Is. 47:6, God executes justice for the widow and curses those who pervert justice for the widow.
Deut. 14:29; 26:12, 13:24:19:21; Acts. 6:1-7; 1Tim. 5:1-16; John 19:26, 27. God provides for the financial and material needs of the widows.
Deut. 16:10, 11, 13, And 14; Zech. 8:3,4. God makes special provisions to include the widow in the convent life of his people. This may well indeed have implications for the presence of the elderly at the Lord's Supper, the New Testament feast of God.
Is. 9-17. God's special attitude toward the widow is compassion
1Tim. 5:1-16. Further New Testament applications are detailed
Luck 7:11-17. Jesus has compassion on the widow of Nain, exercising his redemptive power on her behalf.

Old age can be a time of special trial. Old age can be a time of fear and anxiety.

Ps. 71:9-13. The vulnerability and weakness of old age is a special concern even for the righteous
Eccles. 12: 1-7. This often reads as a classic description of the infirmities of old age.

Old age can be a time of failing health

Eccles. 12:1-7. This description is worth a rereading
Gen. 27:1-48; 1 Sam. 4:15; 2 Sam. 19:35; 1 Kings 14-4. The eyesight and senses of the elderly often fail (for positive benefit of this, see 2Cor. 4:16-18; 5:7.)
2 Cor. 4:16-5:10; 1 King 15:23. Age brings decay to the outer man

Old age does not always diminish strength

Deut. 34:7. Moses was strong and healthy at 120 years of age
Josh. 14:10-12. Caleb remained strong into his eighty-fifth year

The opportunities and responsibilities of the elderly. God's expectations of elderly Christians.

Old age provides opportunities

Ps. 71:18, 48:13. Old age provides opportunity to show God's faithfulness
Ps. 90:12; Heb. 5:14. Old age provides an opportunity to become wise
Lev.19:32; Rev. 1:14 (Dan. 7:13). Old age provides an opportunity to "picture" God, the ancient of days.
Matt. 24:13, old age provides an opportunity to persevere

The elderly can be a benefit to others

Job. 12:12; Kings 12:6. The wisdom gained through long life can benefit others
Ps. 37:25, the experience of the elderly can provide spirit-dual encouragement
Ezra. 3:10-12. the elderly can be a source of tradition, order and roots.
Ps. 92:12-15. Elderly saints are pictured as a flourishing tree

The elderly are to flourish and grow in faith

Ps. 1:1-3; Phil. 1:9; 1 Thess. 4:1, elderly are to flourish
Eph. 2:19; 1 Pet. 2: The elderly are to be in the house of the Lord
John 15; Gal. 5:22, 23; Matt. 5-7; Eph. 4-6; 2 Cor. 4, 5. Inner character development is always a responsibility and opportunity for the Christian.
Ps. 71:15, 24; 37:25; Phil. 1:19-26. The elderly are to display and proclaim the Lord's uprightness, and steadfastness.
Luke 2:25-28. Simeon and Anna are two New Testament illustrations
1 Tim. 5:5,6. Here a real widow gives us a picture of what is expected of elderly Christian women
Titus. 2:2-5, 11-15. Paul gives specific commands to the old men and woman
Eccles. 11:8; Joel. 2:28, Acts 2:17, Zech. 8:4. May be consulted for further study of the responsibilities of the non-Christian

Under obligation to love of God with all his heart, soul, mind and strength

Rom. 3:23 all have sinned
Phil. 2:10. All men, then, must submit to the lordship of Christ Jesus

The church's responsibility to the elderly

Lev. 19:32; 1 Tim. 5:1,2. The church must honor the elderly
Jas. 1:27; Matt. 25:36. The church must visit the elderly
Ps. 71:9, 18. The church must not forsake or cast off the elderly
Deut. 16:11, 14. The elderly, especially the widows, are to be included in the community life of the church.
2 Sam. 19:31-40. The desire of the elderly to stay at home should be honored.
1 Tim. 5:4, 8, 16. The family's role for elderly care
1 Tim. 5:3-9; Deut. 14:29. The church is called upon to provide for the widows
Ps. 68:5, Deut. 10:18, Ex. 22:21-24. Jer. 7:6. Even God executes justice and protects widows.

The churches' preparation for old age

Ps. 71:6; John. 15:1-11. The elderly need to be taught to trust God
2 Tim. 1:5; Gen. 17:7; Ruth. 4:14-17; John. 19:26, 27. Families must be developed
1 Tim. 5:10-16; Titus 2:2-5, 11, 15. What is expected of the elderly?
Titus. 2:2-5. Opportunities for the elderly to instruct the young
Gal. 6:7. The aging process needs to be understood. Physical, mental and spiritual consequences of our manner of living.
Ps. 1:2. Here development of a life of prayer and meditation is encouraged.

The churches' responsibility to non-Christians

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1 Gal. 6:10. We are to do good to all men as we have the opportunity
Matt. 28: 19, 20 we have been commissioned by the Lord to make disciples of all nations.

Ministering to the elderly

1 Cor. 10:3. Motives for working with the elderly
2 Cor. 1:3-7. To worship and thank God
Gal. 5:6 to show our faith
Matt. 7:24-27, Matt. 25:31-46; Jas. 1:22-25; 1 Tim. 5:1-6. To obey God's Commands
1 Cor. 12:12-27, Rom. 12; Col. 2:19; Eph. 4:15, 16. To build up the church

The privilege of working with the elderly

Matt. 25:40; Rom. 8:29, 2 Cor. 3:18. To be with Christ in his work, becoming more and more like Jesus
Gal. 2:20; 1 Tim. 3:13; Jas. 1:25. To know more of God's love, mercy and compassion
2 Cor. 4:18. To be involved in the temporal sickness and suffering that so often point up the eternal realities: life, death and judgment.

WORKING WITH THE ELDERLY

Show care for the elderly. Encourage staff members and pray for their needs.

Encourage the development of talents and abilities for the elderly
Encourage friends and family to join your efforts
Be sensitive to family relations
Give small gifts and cards on Birthdays and Christmas
Share the greatest gift, the love of Jesus Christ.

CHAPLAINCY:

Chaplains who minister in a nursing home are a topic that has had considerable discussion. There are many who believe our main purpose in visitation should be to befriend the elderly and help meet their physical and emotional needs, offering spiritual guidance only if it is requested.

Others stress the priority of direct evangelism and desire to submit all other aims to this one overreaching purpose. Elderly people are so near to death, this group claims that we must constantly proclaim verbally to gospel and urge repentance lest they also perish eternally.

Many people that the chaplain visits are facing imminent death but this does not mean that there is not enough time for the Holy Spirit to work.

Overzealous chaplains who proclaim that the gospel without first becoming acquainted with the person and accurately determining his or her needs can often do more harm than good. The good news of Jesus Christ is a gift and it must be offered as a gift, not used as a threat or a weapon.

Sickness, an operation, loneliness, grief or depression are all deep spiritual needs that can be met by the gospel as it is offered even by someone unknown to the sufferer. We must be sensitive to

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the fact that God has perhaps prepared someone for us to share the gospel with and we must be ready to give the gift that has so freely been given to us.

There is no right or wrong answer on how to evangelize. The key to discovering what to do in any given situations is the Holy Spirit. God has gone before us and we must respond to what he has already done and is continuing to do in all of our hearts.

Our response may be simply showing God's love through our actions or we may have the opportunity to share the gospel verbally. We must be people of prayer who are actively relying on God's guidance before, during and following visits.

As we seek God's guidance in our chaplaincy, we must not overlook the fact that God has given each of us different gifts. Some people are skilled in the art of friendship. We must share the gifts given to us by God and share directly with people whom we don't know, sharing the good news of Christ. The chaplain should never avoid making friends for fear of becoming involved and committed.

Suggestions that should be considered:

1. A worship service for believers is evangelism for the unconverted. The simple, direct gospel shared throughout a service is an encouragement and comfort for believers and a call to faith for un-believers.
2. Visitation, in the context of an established, caring relationship, is a good way to open a conversation is to share insight of the activity of God in your life.
3. Be sensitive to the needs of the individual. Needs are often clear.
4. Sharing openly with a Christian resident in a room where there are non-Christians present can be another effective method of ministering. Encourage Christian residents to share their faith with other residents who do not know Christ.

Funeral Services: The nursing home may depend upon the chaplain to notify the family upon the death of a resident. In this event the chaplain should offer to assist the family in contacting their pastor and the funeral home. If the family does not have a pastor, then the chaplain may be asked to officiate at the funeral service. The chaplain must be sensitive to the background and needs of the family.

It will be important that the chaplain get with the family prior to the service to learn everything he/she can about the person. Make the person or family feel a part of the planning for the services.

Residents who live in a nursing home have normally been a resident for many years and have formed the same bond, as a "family" with other residents and have grown to love and respect them just like family. It is important that the chaplain realize the grief is not limited to the biological family of the deceased but the other residents as well.

Emergency Services: When an emergency arises in the life of a staff member or resident, the chaplain may be the only one to whom to turn. Be prepared to meet any crisis with a caring spirit

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and an open heart. Persons at the facility must never feel their need is an inconvenience to the chaplain. Do not offer this service unless prepared to give the necessary help.

Tape Library: The chaplain can start an Audio Library collecting sermons donated from local churches, the Bible on tape, and Christian books on tape. Local churches may contribute to this ministry. Residents' families may also wish to donate funds. The chaplain must keep the library in order. Investment in a few tape players for loan would also be helpful. A tape library will bring company and comfort to many lonely lives.

Foster Grandparent Program: Youthful faces always bring a smile to the elderly. The chaplain can enlist children or youth groups from several local churches to adopt a grandparent. The "grandchild" should visit occasionally and send cards on special occasions. Encourage the young person to give their "grandparent" something she/he has made. Target those residents who have no family or visitors. The chaplain must monitor the program so that a child who loses interest may be replaced by someone else.

Birthdays/Special Days: The chaplain may be responsible for planning monthly birthday or holiday parties. Choirs, drama teams and puppet teams may be enlisted from area churches to provide entertainment. Be sure all residents who come leave with a gift or prize.

Classes for Residents and Families: Those who reside in a nursing care facility have special needs as do their families. A chaplain may plan classes to address those needs. Some examples are: Death & Dying; Letting Go; Changing Roles of Child & Parent; Finances; Self-Esteem.

The chaplain may lead in those areas of his expertise, but should recruit experts in these fields to lead the sessions. A survey may be taken of the families to determine the type of classes to offer. The staff can also assist with ideas. All classes should be free of charge.

Family Support Groups: Placing a parent in a nursing home facility is a difficult time for most children. They are confronted with feelings of guilt, helplessness, inadequacy and fear. Knowing others share similar feelings will help these family members deal with their aging parent. The chaplain should schedule these support sessions in conjunction with the administration. The session may be held at the nursing home or a nearby church.

The elderly are often left to the care of strangers. A nursing home chaplain can build bridges of friendship from resident to staff to family to community, in a setting of sterile walls and steel beds, a chaplain can bring an air of hope, care and love. Jesus said, "What you have done unto the least of these, you have done unto me."

CHAPTER 7 HOW TO START A NURSING HOME MINISTRY

Starting a nursing home chaplaincy is actually easier than you might think. Some valuable steps to help you get involved are as follows:

1. Find and select a nursing home in your community.
2. Call the nursing home and speak to someone in authority.
3. Explain to them who you are and what you want to do and ask for an appointment.
4. Meet with the Director/Manager and ask them about starting a one-to-one volunteer program
5. Ask to meet some of the residents and learn the layout of the nursing facility

IDENTIFYING THE NEEDS OF THE ELDERLY

The purpose of a nursing home ministry is to respond to any personal needs that the elderly may have at a very difficult time and place in their life. There are situations that the chaplain will need to focus on and be prepared to respond to. These situations may include:

- Anxiety
- Comfort
- Contentment
- Death
- Economic Adjustment
- Greed
- Hope
- Loneliness
- The Past
- Peace
- Physical Decay
- Self Esteem
- Time
- Surroundings

There are Bible verses for each situation and it is advised that the chaplain be prepared to handle each and every situation and to know what to say. It is the chaplain's responsibility to provide the answer and scripture whenever possible. Do not attempt to provide care, concern or a biblical view if you are not prepared to answer with anything other than scripture.

Avoid questions that can be easily answered with a simple yes or no. One word answers stifle conversation quickly. Questions that seek explanations allow the other person to teach you something about them self, as they do, be careful not to probe too deeply on the first visit. There may be sensitive areas that you should avoid until you know the person much better.

POSSIBLE CONVERSATION TOPICS

- Surroundings
- Family History
- Weather

- Recent News Events
- Spouses, Children, Grandchildren
- Spiritual Concerns
- Sports
- Travel
- Home Towns
- Crafts
- Education
- Employment
- Life's Concerns
- Needs and Wants
-

The chaplain is the one with the resources as a visitor. Look to God to help as you strive to become a person who is more and more fitted to serve. The following characteristics can be of special importance in a nursing home ministry.

Humility: If you have a proper sense of self, then you will not suffer from either pride or false humility. This will enable you to be yourself and allow the elderly to be themselves. We can be humble by recognizing that we don't have all the answers and by treating them as if they were worthwhile because they are.

Vulnerability: We need to know that we know ourselves and have a proper sense of worth. When we can do that, we can open up to others and to the possibility of rejection, criticism, pain and sacrifice as well as to the possibility of pleasure and praise. As we share thoughts, feelings and hopes with others, they see us as "human" and will more readily open up to us.

Commitment: You must be willing to sustain a deep level of relationship with the elderly on a personal basis as long as he/she needs it. If we are not willing to do this, we are not willing for ourselves to be used as we should be. It is through our continued humility and vulnerability and our continued empathy and listening that we really care for the individual.

Empathy: This process involves both our mind and our heart. To empathize, we must be able to understand what is happening to the individual, feel sympathy for what he/she is going through and then put the two together in helping him/her deal with that particular situation.

Listening: Most of us feel that we already know how to listen. However, there is a difference between listening and hearing what is being said. Listening is an art and is not always as easy as it seems.

Listening recognizes the importance of the individual. It shows a willingness to spend time and energy on another's behalf and brings understanding of the situation. There are no short cuts around the need for personal sharing. Listening requires giving up our own interests and concentrating fully and actively on his (Phil. 2:3-4).

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Listening does not mean you have to always remain silent. It encourages the other person to say more, without prying. It gives you time to formulate a response. Without thinking of you, it strives to hear what is not said as well as to understand what is being said.

Scripture: When using our own resources, we find that they are often unreliable and imperfect. The scriptures offer a stability and hope that the elderly can turn to. In a changing and ever changing world, the word of God directs our attention to a perfect God who never changes and who can put order and meaning into our lives.

WHEN TO USE SCRIPTURE

Find the right time: Using scripture too quickly can give the impression that the Bible gives irrelevant answers. Referring to it too late makes it seem like an afterthought. Understand what you are teaching before you attempt to use scripture.

Comfort the suffering: A word of comfort in the context of personal relationship and at the right time can be a blessing. Often the purpose and meaning of suffering need not be seen.

Meet their needs: Don't read scripture merely to meet your own needs. Do not read your problems into the situation or use them as an example. Be ready to share scripture through which God has spoken to you, if it is fitting.

Respond to the Holy Spirit: Don't share from the Bible out of a sense of duty or compulsion. Let the Holy Spirit guide you.

Select the appropriate context: Your choice should be guided by the resident's needs, give yourself time to find out what they need.

Help the person identify with scripture: share passages with which the individual can identify with. This helps with self acceptance.

Choose the appropriate translation: for those who are versed in the Bible, stay with familiar or expected versions such as (KJV). For those who are unfamiliar with the Bible, consider using a modern version that they can read with ease.

Share with one another: Let the residents share with you what they are learning. Feel free also to share what God has been teaching you.

Suggested Scripture Passages:

1. Forgiveness- Pss. 32, 51, 103; Is. 1:18; 53:4-6; Mic. 7:18-20; Rom. 8:1-4; Heb. 4:15, 16; 1 John 1:6-10
2. Comfort- Pss. 42, 23, 116; Is. 40:28-31; 41:10; 43:1-5; Matt. 11:28; Rom. 8:35-39
3. Hope- Pss. 42, 139, 145; Rom. 5: 1-5; 1 Cor. 15:1-1; John 3:1-3; Rev. 21:1-8
4. Love- Deut. 7:6-10; Is. 43: 1-4; John 3:16-18; 14: 15: 9-17; 17:9-26
5. Trust- Ps. 23; 37:3-7; John 14:26, 27; 2 Cor. 4:16-18; Phil. 4:3-7; Heb. 12:12-15; 1 Pet. 1:13-21

WHEN TO PRAY

Appropriate time: for each resident the appropriate time may be different. It is important not to pray with someone before adequate communication has taken place. Then the prayer can reflect to God the concerns that have come out of a conversation.

One must be careful not to use prayer to end conversation. It may well be that after a time of prayer you will want to continue a conversation. Often deep feelings are triggered in response to talking with God. Be willing to stay and respond to these thought and feedings.

Anxious times: pray before potentially stressful situation such as surgery, tests, and unfamiliar changes.

Strengthen believers: faith: pray with those who show some evidence (verbal, written material, etc.) of faith.

Examine your motives: Have their needs on the forefront of your mind. God will give an added blessing by ministering to you too.

HOW TO PRAY

- Focus on God, praise God for who he is and what he has done.
- Focus on needs; focus on what you think the individual would pray for, health, friendship or finances. Discern his hopes, fears and desires.
- Adjust to the person's background. Be aware of the denominational and ethnic background and adjust your style of prayer accordingly.
- Expect god to respond. Only be expecting God to respond can you teach others that prayer is real and is heard by God.
- Be concise. Remember that the elderly often have shortened attention span, so keep your prayers short.

THE FIRST FEW VISITS (Guidelines)

The first few visits are normally difficult and the chaplain must be spiritually and psychologically prepared. However, don't be bound to the suggestions outlined. After reading these guidelines, meditate and pray and open your heart to various possibilities.

Pre-Visit Preparation

Before you go to the nursing home for the first time and in successive visits as well, ask yourself the following questions:

Have I taken time to pray?

- For myself
- For those I am about to meet

- For the staff of the home
- For others going with me

Do I have a goal?

- Help write a letter
- Talk about God
- Chat with three people
- Lead a worship service

Do I have the material I need?

- Bible
- Games, Puzzles
- Small gifts
- Writing materials
- Musical instrument

How do I look? How do I feel?

- Dress usually not too casual
- Cheerfulness, would someone want to talk to me
- Motives, am I trying to serve God? To serve the elderly
- Breath-Many will be hard of hearing and I will have to talk “close up”

FIRST VISIT

Contact the nurse in charge where you want to visit. Be sure that the staff knows that you are there. If you need to check in by signature, be sure you follow their rules and sign in. Ask who is ill or may need visitors.

When you arrive at the door of the individual’s room knock first before entering and wait for permission to enter. Enter slowly and tentatively, especially if the person is hard of hearing. Do not violate the “private space” of any resident.

You may wish to begin visitation by meeting the person in an open lounge. That will also help you to become familiar with other residents. However, it often presents many distractions and interruptions.

- Introduce yourself- tell the person something about yourself.
- Be honest, concerned and direct
- Find objects or subjects to start conversations (flowers, movies, news)
- Don’t focus too quickly on religion. Get involved in general conversation first
- Leave literature that may be helpful in a particular situation.

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When you leave, tell the residents when you will be back. Don't promise more than you can do. Be faithful to your word and they will learn to look forward to you coming back.

If you are unable to return when you say you will, CALL and leave a message for the person you were supposed to meet with.

After you leave, write reminder notes, reflect on your visit and pray. Before the next visit make a note of scriptures that may apply to the person's needs or situation and meditate on it, praying for wisdom as to how and when to help meet those needs. Seek prayer from others for help.

SECOND VISIT

Review notes from the first visit. Pray and meditate on the response you think would be appropriate for the visit. Follow the same basic procedure as you did in the first visit, noting the following:

- 1) Be ready for any changes that may have occurred, new roommates, death of a resident, good or bad news, and change in mood. Adapt the response you thought would be right to fit the new situation.
- 2) Enter again with an introduction that assumes neither too little nor too much. Give simple clues to your identity as needed. Stimulating people to remember provides good mental exercise and helps establish a proper sequence and time, consciousness. You may meet with some resistance due to laziness, neglect and/or physiological disability. Don't push too hard or too fast for recall.
- 3) Try to undo any misunderstandings that may have arisen from the first visit. Plan not to repeat your early mistakes such as: monopolizing the conversation, talking too fast, or too loud. Be prepared to listen better. Apologize if it's necessary.

THIRD VISIT

As you spend time with residents you may not need to take notes. If you are visiting a large number of residents, you may need to relate to your notes for a while.

The following are suggestions:

- 1) Since elderly residents are much older and (relatively speaking) close to death, and others may be sick and actually very near death make every visit count. Be there for the person and give each one your undivided attention.
- 2) Don't promise anything you can't keep and don't leave false expectations about what you can or what you might do or when you might visit again.
- 3) Work towards helping with particular problems or concerns. If confrontation or exhortation is needed, be sure you have established a sufficient basis of trust, respect and rapport.
- 4) Encourage spiritual examination and life review (i.e. past life, successes and failures, unsolved feelings or conflicts etc.) continues a program that moves forward in personal, meaningful examination of self issuing in service to God and others. Avoid dwelling in the past that can't be changed, concentrate on learning from mistakes and improving present attitudes and behaviors.

- 5) Seek ways to be involved even if you aren't there. Consider their needs and work on a plan to meet their needs. Write letters for them, take them to eat, take them to church. The possibilities are endless.

SPECIAL SITUATIONS

Those who already have visitors: Sometimes when you go to visit an individual they will have visitors. Normally, you should give way to prior visitors, although you may wish to get acquainted and talk with them if they seem open to conversation. If the visitors are family members or friends are eager to meet them and get acquainted as they have a lot of influence on the resident. As the occasion arises, introduce yourself, keeping in mind that there may be needs in the family (economic, social, and spiritual) to which you may wish to respond.

Those who are blind or have limited vision: Approach the blind person directly and speak to them face to face. Don't assume that because they have difficulty seeing, they also cannot hear well, don't shout; use a normal speaking voice but speak clearly, slowly and distinctly. Touch can be important to a blind person, but speak before you touch them or you may startle them.

Remember the importance of other senses to a blind person such a smell and touch. For example: if you are bringing them flowers let them smell and touch them. Describe things from the environment and your own experience for that person. If the person is not totally blind, wear bright colors and bring large print literature.

Those who are deaf or hard of hearing: if the person is totally deaf, consider writing communications. Stand facing them so they can see your facial expressions and read your lips. Touching the person gently is a good way of getting their attention to you before you begin speaking. Touch is also important for the hard of hearing. If they are hard of hearing find out which ear is their good ear. When speaking, speak slowly, distinctly and simply. Lowering your volume is better than speaking louder.

Those who are very ill: Residents who are seriously ill will most likely be bedfast. They also appreciate your visits. However, do not over stay your welcome. Check with nurses about their condition and ask permission to visit. Never demand participation on their part for visitation or activities. They may be too weak or in too much pain to communicate verbally. Be alert to eye communication. A gentle touch and few words may be the best expression of love. Words of comfort and assurance and a brief prayer are often appropriate. Never ignore, bypass or discard a person who is very ill.

Those who shout: Attempt to find out why they are yelling. They may be deaf or hard of hearing or in need of attention either medical or personal. There may be a legitimate need that is being ignored. They may have genuine spiritual problems related to unresolved grief or loneliness. A gentle touch and the assurance of your presence and care are again very important.

Those who physically cling to you: Physical touch is very important in communicating the concern and love you feel for the elderly. It is virtually a universal need among them to be touched and in some instances you may need to deal with the excessive "needs".

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Be alert to potential difficulties and handle them in such a way as to keep a proper balance of expressing genuine caring, but not acceding to improper gestures.

Those who are from other denominations: you will differ with some residents in religious matters. Try to determine if there is a genuine Christian faith. A genuine Christian faith can come to expression in a variety of ways:

- Do not be judgmental
- Do not argue
- Do not push your religion
- Do not “preach” your religion
- Do not debate the differences
- Do not avoid or get angry

Those who do not speak English: There are many different languages in a nursing home. It may become necessary for you to find someone who can interpret for you. Touch is important for someone who cannot communicate. Printed literature can also help someone who cannot speak or understand English. Bibles are available in other languages.

Those who complain: Be sure you listen to someone who complains and try to look at things from their perspective. If a complaint is valid attempt to help. Do not get involved when there is nothing that you can do. Respond realistically often with a sympathetic ear or a word from scripture. Avoid flipped answers at all cost. If an individual persists in complaining during every visit, feel free to speak up and their attitude but don't be condemnatory. Always be sure your love for them shines through.

Senility: The term senility is no longer in use today. The appropriate medical term is dementia, though there are many forms. When we hear the term senile we often think of confusion and disorientation as to time and place, hopelessness, lack of self care, forgetfulness, inability to carry out everyday tasks, second childhood and impairment of intellectual functions. Usually we consider all of these to be the price of old age and unfairly assigned to the aged.

There are two classes of mental impairment: Functional impairment is often the result of depression. Organic impairment means actual impairment of the brain tissue itself and is termed organic brain syndrome. Organic brain syndrome (OBS) may be acute, resulting from causes such as malnutrition, misuse of medication, pneumonia and thyroid conditions just to name a few. In some cases it may be temporary and without care this condition may become one of four chronic OBS diseases.

Though the symptoms of senility may have organic causes, it is often difficult to determine whether they are the result of OBS or simply the depression, loneliness, grief, guilt, loss of self esteem, indifference to others and feelings of uselessness. When visiting nursing homes, be prepared not to attempt to judge the medical condition of the apparently senile, but to respond to the emotional and spiritual needs as best we can discern them.

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When establishing a meaningful relationship with someone who appears to be senile there are special needs to be taken care of since they do not always understand or respond to our idea of a normal conversation. Here are some suggestions for making conversation with someone who appears to be senile:

1. Attempt to engage the individual in conversation about present realities. Talk about matters of concern now. Talk about the community, news, nation or world matters. Gain their attention and interest and then proceed from there.
2. Join the person where they are. Usually the confused person will talk about unrelated realities or about subject from the past that do not make any sense to you. The subject is real to them and you should just listen. Often it is bitterness, resentment, hostility and unrest that keep the person in the past. Counsel to them about forgiveness and mercy.
3. Help the person recall important and meaningful things from the past. Reminisce about a job, hobby, friend or family member and help them focus on thoughts and feelings.
4. Don't be alarmed if the person gets upset or cries at the reading of scripture or even the mention of God and prayer. For many, you are probably the first person in a very long time that has shown concern about them.
5. Love and concern communicate more loudly than words. Physical touch is important.
6. Prayer can be very effective, especially if it is short, concise and relevant to the person's needs and desires.
7. Continue your efforts at establishing relationships regardless of any lack of response or progress. When possible, share the gospel even if there seems to be no communications established. John 3:16 is appropriate and can be spoken even when the person seems to be in another world. Leave the rest to God.

NEW CHAPLAINS and VISITATION

After you have been involved with ministering in a nursing home, there will be more chaplains who desire to get involved. Many chaplains are drawn to visiting with the elderly however, many are not emotionally equipped to handle the job. Many have hesitations and reservations and the following are some suggestions for introducing other chaplains to a rich, rewarding experience in nursing home ministry.

1. Ascertain as much information as possible from the prospective chaplain before they attempt to start a ministry or assist you with your own ministry. Do a background check and talk in depth to see if they would be a good chaplain.
2. Inform the chaplain about procedures and what may or may not happen and about the program goals.
3. Discuss details about visitation, such as dress, manners, rules and regulations of the nursing home.
4. Pray with the chaplain and make necessary arrangements.
5. Be in charge. Take the person with you. Let them observe you and learn from the visits that you do.
6. Go to the comfortable spots first. Don't initiate a situation threatening to either the new chaplain or the residents.

7. Be sensitive to the chaplain's reactions. Be there for support when feelings of discomfort, enjoyment, and eagerness arise. Keep encouraging them to share their feelings and thoughts with you.
8. Help them recognize the part they can play in the chaplaincy program. Give them the opportunity and the freedom to respond in their own way.
9. Discuss feely the degree in which they prefer to lean on you for support and guidance or to take initiative and find their own place within your chaplaincy program.

FINDING A NURSING HOME/FACILITY

There may be a large number of nursing homes or facilities in your area. It's best to weigh a number of factors when selecting the right nursing home for your program. Among the factors to consider are:

- You may want to visit several prospective nursing homes. You may notice that you feel particularly drawn to one. In particular, you will want to keep an eye out for the nursing home where you feel most needed, which we have found often corresponds to the nursing home where the residents are the most spiritually needy.
- You may want to select a nursing home that is centrally located to your home or location. If you get a call that you are needed, the closer you are the faster you can arrive on scene.
- Select a nursing home where the Activity Director is friendly and appears to be interested in working with you when you describe the program to him/her.
- It is perfect acceptable to just pick a nursing home at random, start visiting. There is no magical formula for picking the right one.

THE ACTIVITY DIRECTOR

All nursing facilities have Activity Directors who coordinates activities and volunteers for the home. When you contact this person, tell them you would like to start volunteering and ask to schedule an appointment to come in for an orientation. Tell them you would like to start visiting some residents that get few or no other visitors.

You can begin by volunteering on your own before you decide you are ready to start a volunteer group. Here are some other important questions to ask at this meeting:

- What are the visiting hours, and can volunteers visit in the evening if necessary?
- May I bring other volunteers with me? What sort of orientation would be required for them?
- What are the best hours for one-to-one visiting, so as to not conflict with meals or other activities?

NOTES

CHAPTER 8 WHAT IS VISITATION

The concept of visitation in the Bible is much more full and rich than our concept of “dropping by”. To visit implies that one wishes to show concern and interest in another person. Exodus 3 for example, we see God visiting Moses: “dropping by” in the form of a burning bush that promises to deliver the Israelites from bondage through the one being visited, no less!

The word “visit” is also found in Psalm 8:4 where the wonder of a mighty God caring for insignificant man is discussed. In Matthew 25:36 visiting seems to imply caring for the needs of someone who is unable to care for himself. This idea is further elaborated in James 1:27, where doing what God commands are seen in terms of being like a father to the orphan, and a husband to a bereft wife. Visitation implies a deep commitment evidenced in a practical demonstration of God’s love.

In the Scriptures God himself is often seen as a visitor. His visitation is his coming in blessing (Ruth 1:6; Jer 29:10) and cursing (Lam. 4:22; Hos. 8:13). Likewise the coming of Jesus is spoken of as a visitation that brings both blessing (Luke 1:68; 78;7:16) and curse (Luke 19:44).

The intention of his first visitation was gracious (John 3:17), although it resulted in judgment for the rebellious (John 9:39). His second coming or visitation (1 Peter 2:12) will also be a time of blessing for the righteous and judgment for the wicked (2 Thess. 1:6-10). Although gracious, as Jesus was, it will inevitably result in judgment for the unbelieving (2 Cor. 2:14-16).

Love for Jesus should be our supreme motivation of the elderly. Our concern and our desire to care for and protect depends on our love for our Lord and Savior who loves us (1 John 4:20). As we seek to learn more about visiting the elderly, let us remember that we are really learning more about our loving God (Matt. 25:36-40).

Try to accept and understand this. While institutionalization can be a challenging and stressful experience for all concerned, it is a reality of life for you and the elderly now. Having realistic expectations and insight about yourself, you’re elder and the institution will facilitate this transition in the elder’s life. This understanding will give direction to your future visits and facilitate meaningful times together.

Your prior relationship with the elder will affect your present relationship. The meanings we attach to our family ties continue to influence our participation in our relative’s life. Visiting is a way to heal strained relationships. All families have their histories and their stories.

Family members have a multitude of intersecting relationships, some of which are close, and others which might be distant or frayed. When your older relative needs assistance in daily living activities and increasingly needs to depend on others, relatives and friends have many opportunities to mend, forgive and heal strained relationships. Just being there tells your relative that you care.

Helping with small, everyday things, such as combing their hair, putting on jewelry or a tie, or giving a massage, communicates that you care and gives emotional comfort without any words needing to be expressed.

You can also create opportunities to share some of your own thoughts and feelings about understanding your relative's life by appreciating and validating their struggles, adversities and accomplishments. It is about accepting them as a person, and telling them some of the things you've often wanted to say. Sometimes it is about forgiving, accepting and understanding.

Visitation is an area where the Activity Director can be of great help. The residents who are most in need are the ones who:

- Persons who do not have anyone visiting them on a regular basis.
- Who are confined to their room, or choose to stay in their room for some reason.
- Do get out of their room, and do not interact with the nursing home community.

Activity Directors have to make sure that each resident is involved in activities, even if they do not leave their room. Someone who gets daily family visits may or may not be the neediest resident at the facility; use your good judgment as to who would most appreciate visitation.

In addition, the Activity Director may give you the name of someone who is unable to interact very well with volunteers due to issues such as dementia or communication problems. This person does indeed need human contact, but may be a little too challenging for a brand-new, inexperienced chaplain volunteer. You may want to select residents who are able to communicate reasonably well with your brand-new chaplain volunteers.

Once you have obtained a list of possible residents to visit from the Activity Director, take the time to meet them, to get a better feel for whether they would be good residents for you to try to visit, and to find out if they would be interested in receiving a daily or weekly visit.

Most residents are interested, but some are not, and that is their prerogative. Some may say no at first, because they may not understand what you are all about, and why you want to visit them, but they might be willing to give it a try for one visit, to get a better sense of what to expect.

Explain who you are and what you do (you may need to simplify or expand your explanation depending on the level of awareness of the resident), but if they say no, do not force the issue. The same goes for the family members of the residents.

Resident selection is very important, but you should not spend too much time worrying that you have selected the perfect residents. If you are visiting some residents who seem lonely, smile when they see you, or give off other signs that let you know they appreciate your visits, you have succeeded.

WHO NEEDS VISITORS

Every human deserves, graves, and needs attention. For every one who cries out, there are millions as equally entitled to that same attention. Unfortunately no one can help everyone and determining which one of a million cries you hear is more deserving than the rest can be an impossibility. Nursing care facility Chaplains reach out and take hold of the ones who happen to be nearest and that know they can help.

We should value all ages in our communities, from the very young to the very old. But the oldest old in nursing care facilities often feel isolated and excluded. Developing stronger connections between these older adults and their community can have tremendous benefits for young and old.

Even older adults with serious memory loss can still enjoy a visit, even if they don't remember it later. Elementary-aged children, especially those in fourth to seventh grades, often value the opportunity to make a difference in an older person's life.

They are eager to help in a nursing care facility once they become comfortable. They learn how to interact with people different than themselves and they learn responsibility and they learn that older people depend on them.

While a single visit to a nursing care facilities are a valuable experience for children and will brighten the day for older adults, an ongoing visitation program is most effective. An ongoing series of visits allows the understanding and trust to develop which are essential for a real connection between people of any age.

Talk about what to expect during a visit, prior to entering a nursing facility (e.g. residents in wheelchairs, unfamiliar smells, some residents may not seem responsive, etc.). Answer any questions or concerns young people may have.

GENERAL TIPS FOR NURSING HOME VISITS

Visitation is the heart of every nursing care ministry. In this module you will find numerous practical suggestions concerning visitation.

Much of this module is no more than common sense but it is of great value to you to contemplate some of these common sense guidelines and suggestions as you prepare for your humble ministry of visitation and great responsibility in the Kingdom of God.

You are a volunteer so use your maturity and discernment as you share what you are doing. Don't be pushy or a Bible Beater, it will possibly lead to arguments over religious matters. Chaplains are "neutral" or non-denominational. Compromise is not necessary just wisdom.

BASIC GUIDELINES FOR VISITATION

Be Prepared:

- Keep your personal relationship with God in good shape
- Seek support (prayer and fellowship)

Be Sympathetic:

- Learn and develop good listening skills
- Learn to hear what you are listening to, not what you think you hear
- Act in humility, don't think or act superior

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Be Honest:

- State why you have come
- Give hope, not false hope

Be Attentive:

- Talk to individuals and learn their names and any information they tell you, write it down
- Fix your attention on what is being said and who is saying it
- Respond to questions and situations as well as you know how
- Involve yourself with people not with impersonal, distant problems.

Be Open:

- Share yourself, your hopes, fears, interest, even discouragement (BE REAL)
- Be friendly, outgoing.

Be Sensitive:

- Accept the individual for who he/she is
- Encourage openness, don't monopolize conversations (IT'S NOT ABOUT YOU)
- Ask questions about interests, family, past employment, likes and dislikes, friends and current events.

Be Consistent:

- Commit yourself to faithful visiting
- Continue even if it's boring or you face rejection. You are not visiting to meet your own needs, but to serve other in obedience to God. Keep trying!
- Visit at appropriate times, not late or too early or at meal times unless you are helping with feeding.

Plan a visit at least two weeks in advance. Let the activities director know what you are trying to do and when the children will be coming. They can often suggest the residents who would most welcome a visit (some older adults are in higher care units than others). The best times to visit are generally mid-morning from 10:00-11:30 am, in the afternoon from 2:00-4:30 pm, and sometimes in the evening from 6:00-7:30 pm.

Since visitors may be rare, the activities director will probably put your visit on the calendar of events so that residents can look forward to it. Babies and toddlers who are full of grinning energy make good visitors, as do older children and teenagers. For toddlers, make sure they've had a nap beforehand and are fed.

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You can make the visit informal, just talking with and moving to various residents one-on-one, or you can plan to do a presentation like a short play or a series of songs (you can even invite residents to participate in familiar songs by singing along or clapping).

Children can also bring gifts for the residents, like drawings or colorful, handmade cards (many ideas are included in the various Legacy Project activity kits). Or work on a project beforehand like making a scrapbook of funny cartoons (which children have either drawn or cut out of the newspaper) to share with residents.

Other appropriate gifts for special occasions include live flowers, a colorful lap blanket or pillow, and warm, soft slippers (with a good tread) or sweaters. If you want to bring food, make sure you clear it with staff beforehand.

If you're going to be visiting with specific people, learn something about them beforehand, their interests, background, limitations, and needs. And although some behavior may seem childlike, remember that older adults are adults, not children.

Acknowledging a person's personal history and lifetime of experiences is what allows older adults to maintain their respect, dignity and, often, their connection to the world around them.

Remember that the care facility is home to the older adults and you should respect their privacy and living space as much as possible. When you're entering a room, even if the door is open, knock first.

One-on-one visits will vary. You may find residents in the lobby, hallway, garden, community room, as well as their individual rooms. Start a conversation by introducing yourself casually: "Hello. My name is... Would you like me to visit with you today?"

Some people may not want to visit, but most will say yes. Your interaction will be short or long depending on the person. Even a few minutes can brighten a resident's day.

Questions about sports or hobbies the older adult might be interested in or their memories of their schooldays may be a good conversation starter. Most residents have time on their hands and your visit will probably seem short no matter how long you stay.

Don't feel obligated to solve the personal problems of a resident. Just being there to listen and empathize is important. At the end of each conversation, before you move on to visit with the next person; thank the resident for spending time with you.

You can shake their hand or offer to give them a hug. If a person doesn't want you to leave, try to get them involved in another activity, take them to be with a group of people, turn on the television, or place something in their hands like a small memento that they can hold on to.

Keep promises. Don't promise to return if you aren't able to come back. Never say anything unless you mean it. After a first visit to a nursing facility, talk about what happened and how

young people felt. Do you think you made a difference in the lives of the residents? Why? What did you learn about older people? Do you think visiting older people is important? Why?

One of the biggest barriers to young and old coming together is often difficulties communicating. They may not know what to say to each other, feel uncomfortable, or are unsure about how to make a meaningful connection. A great introduction to communication in general is storybook communication. It explores the many forms and aspects of human communication and is a good starting point for intergenerational communication.

For older adults with few functional limitations, reading a picture book with a child can be a great icebreaker. Reading takes the pressure off both young and old to "entertain" each other. Other simple activities to help older adults communicate with the young include the "Hot -- and Not List" and "Grandchild Interview" in the Communication & Storytelling section of the Grandparents Day Activity Kit, and the "Did You Ever...?" activity in the Storytelling for Hope section of the Holiday Activity Kit.

Children might want to do an interview with older adult using pages from the "Generations Scrapbook" activity in the Scrapbooking & Other Photo Fun section of the Grandparents Day Activity Kit, or use the "Grandparent Interview" activity in the Communication & Storytelling section of the Grandparents Day Activity Kit.

Teenagers can take the lead in communicating with older adults using the "Fill-in-the-Blanks Life Story" in the Storytelling for Hope section of the Holiday Activity Kit. The Ages & Stages section of the Grandparents Day Activity Kit also has useful information and activity ideas.

Here are some tips to help children, teenagers, and adults communicate with older adults with serious cognitive or other functional limitations:

Begin a conversation with orienting information. Identify yourself, if necessary, and call the other person by their name. Say something like, "I'm here to visit with you."

Reduce distractions to minimize the person's confusion -- noise (e.g. phones ringing, people talking, even street traffic), crowding, glare, unrelated activity, etc. Even moderately impaired people can "overload" from too much distraction and may withdraw, have outbursts, or attempt to leave.

Be aware of how you're presenting yourself. Are you angry, tense, or frowning? Older adults can be extremely sensitive to nonverbal signals like facial expression, body tension, and mood. If you make a point of being relaxed and smiling a lot, the other person is more likely to respond in the same way.

Touch and emotional tone are important. Take a calm, gentle approach. Reach out and make physical contact at appropriate times during a conversation (e.g. touching a person's hand in a comforting way).

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It's important to be at eye level with the person you're talking with. Look directly at them when you speak, and make sure you have their full attention. Use your normal conversational tone, but take into account any hearing impairment (e.g. favor good ear).

Speak slowly, articulating each word. Use simple, straightforward sentences. Be clear, but not patronizing. Take your cues from the other person to determine what they do and do not understand. If necessary, slowly and calmly repeat a statement. It may take several repetitions before the person understands you. Supplement words with nonverbal gestures to reinforce or explain your message.

Be patient. You need to allow time for the older adult to absorb, understand, think, and respond. The capacity to understand is usually greater than an older person's ability to express themselves verbally. Don't put a lot of emphasis on expecting answers to your questions, like "Tell me about your day?" or "What did you have for lunch?" Instead, provide them with information.

When you do ask questions, ask one at a time. Start by asking questions simply, in a way that requires only a "yes" or "no" answer. If a person is able to communicate more, they will, and you can adjust accordingly.

Use statements that emphasize the "here and now" (e.g. "I like your sweater"). At the same time, linking to the past can evoke fond memories and help structure a visit (e.g. looking through old photos).

Respectful, polite listening is often what people want most. They may seem to be rambling, but even the attempt to communicate with you is a good sign. Respond not only to their words, but also to their emotional tone. You can acknowledge a feeling by saying something like, "You sound very sad."

If you don't understand something the person says, apologize and ask them to repeat it. Try to focus on a word or phrase you do understand and build on it. If you make a guess, phrase your guess as a question to help minimize frustration (e.g. "Are you saying that you like my ring?").

Be prepared that not everything the person does and says will "make sense." For example, a person may ask if you like the hat they're wearing when they're not wearing a hat. You can smile respectfully and move on to talking about something else.

Be aware of changes in mood or behavior during a visit and adapt accordingly. If a person becomes upset or angry, don't try to reason or argue with them. It will only make the situation worse.

The person may no longer have the ability to be logical or rational. Try cheerfulness, humor, or distraction to politely move on to something more positive. Ignore a verbal outburst if you can't think of any positive response.

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To minimize everyone's frustration, focus on what the person can do instead of what they can't do. For example, if a person wants to go outside and it's winter, suggest looking through a magazine together.

You don't need to fill every moment with conversation. Just sitting and looking out the window can be enough. There are many ways to communicate -- familiar songs, favorite foods, holding hands, walking.

Respect the person for the adult individual they are. And remember that even someone with serious memory loss can still enjoy the moment. A compliment, shared joke, or caring smile makes everyone feel good

WHAT TO SAY

It's hard meeting residents and to know exactly what to say to a resident when you meet them and how to explain who you are and what you're doing. It may be best to have an activity director or nurse go with you to introduce you to the residents. A good starting line is:

"Hello, my name is _____. What is your name? It's nice to meet you. I'm a volunteer chaplain here and I wanted to get to know you better. Would you mind if I pull up a chair and sit down?"

Once you get started, here are a few other ideas of conversation topics:

- It's a nice day outside isn't it?
- How are you feeling today? What you have been doing all day?
- Did you have anything good to eat for lunch today?
- Are you from around here? Where were you born? I was born in Alaska have you ever been there?
- Next Monday is Veteran's Day. Do you know any veterans? Or whatever holiday is coming Up.
- My kids are at school right now. Did you have any children? What are their names? Where do they live now?

Finally, when you are ready to leave:

"I'm going to be back again this same time next week. Would it be o.k. if we talked some more?"

You may have to try this with every resident but once you do, and if they enjoy it, the other residents will want to get to know you also. Most of the time, you will find at least one resident who will be delighted to have someone to talk to. Occasionally, they will tell you to come back another time. Rarely, they will tell you to "go away!" If that happens don't take it personally.

Most conversations will be quite similar to the one just described, except that you will probably want to fit in a few pointed questions to get a better sense of whether or not they have any regular visits from family and/or friends.

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You will probably want to assure them that they do not have to continue visits with any you or any other chaplain volunteer if they do not want to; just ask if they would be interested in meeting some of them. If not, do not force the issue; just thank them for allowing you to talk with them.

If you have an elderly relative or friend who has moved to a nursing home or assisted living facility, you know that your relationship has changed. Elderly people who are unable to live independently often have a chronic illness or some level of dementia that makes self-care – and communication – difficult.

While communication with an elderly person may be more challenging, it's worth the effort. By maintaining a loving connection with an elderly person, you honor your relationship, and help to improve that person's quality of life.

WHY CHAPLAINS NEED TO VISIT

- There are over 1.6 million people living in long-term care centers in this country alone, and that number is expected to increase by 50% within the next 10 years.
- Almost 60% of the institutionalized elderly never have anyone visit them, including their own family members, pastor, or fellow parishioners.
- Many elderly people are lonely because they have lost or become separated from companions, friends, and families.
- With nothing much to do, time passes slowly for them, and many days seem monotonous and empty.
- Increasing physical infirmities cause them much concern about the future.
- Many of the institutionalized elderly find group living difficult to accept and manage.
- Most frail elderly people are searching and very hungry for spiritual nourishment.

BE A CHEERFUL GIVER

Chaplains should always utilize interpersonal skills of friendship, compassion, listening, understanding, and encouragement when working with residents. Below are some pointers for nursing home care spiritual providers.

Friendly Visitor: Visit one-on-one with the elderly residents and share their experiences and become their personal friend and spiritual confidante if requested. One hour per week or more.
Worship Assistant: Help the activity director assemble residents of an elder-care center for their monthly worship service, and attending to their needs. One hour per month or more for each care center visited.

Bible Class Teacher: Teach informal Bible studies to groups of interested senior citizens in retirement centers. One hour per month or more, plus lesson preparation time.

Pianist/Musician/Vocalist: Assist in leading worship services and sing-along with residents of nursing homes. Musicians who play the piano or guitar are especially enjoyed. One hour per month or more.

Intergenerational Visitors: Start an "Adopt a "grandma" or "grandpa"" through an elderly adopt program! Have mothers take their baby to a nursing home, letting the residents hold, rock,

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receive from and express love for the child. This develops for all involved the ability to bridge generational differences and appreciate common human needs. One hour per month or more.

Arts and Crafts Instructor: Teach various handicraft skills to small groups of seniors in elder-care centers. You'll need know-how to adapt different arts and crafts in this setting. One hour per week or more.

Pet Sharer: put together a pet program! Take a pet (usually a puppy or mild-mannered older dog) to residents, letting them stroke, receive from and express affection for, and "talk" with the animal. You must know your pet's temperament and maintain control of its behavior during the visits. One hour per month or more for each care center visited

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CHAPTER 9 HOW TO COMMUNICATE WITH THE ELDERLY

Physical changes can affect communication:

Age-related decline in physical abilities can make communication more challenging, and some illnesses make communication more difficult. A hearing loss makes you harder to understand, so be patient and speak more clearly. Face the person when you talk, and avoid talking while you eat. Check to see if an assistive listening device could improve communication by phone.

Vision loss makes it harder for the elderly person to recognize you, so don't take it personally.

Some elderly people experience changes in speaking ability, and their voices become weaker, or harder to understand. Be patient when listening, and be aware of when the elderly person gets tired and wants the visit to end.

Some age-related memory loss is normal as people grow older, although people experience different degrees of memory loss. Most often, short-term memory is affected, making it harder for an elderly person to remember recent events. Keep this in mind, and practice patience. Allow the elderly person to reminisce, and to grieve.

When someone lives to be old, it's impossible not to experience some feelings of significant loss. The deaths of relatives and friends, losing the ability to work and be independent, changes in health and finances, and being unable to make simple decisions can all affect an elderly person's self-esteem.

These losses can create sadness, and grieving. Common responses to grieving are depression, social withdrawal, and irritability, so look for these symptoms in the elderly person and seek medical advice or counseling.

Respect the elderly person's background, knowledge, and values:

Because an elderly person's life experience may be very different from yours, it's important to let the person express those thoughts and feelings, and to respect them even if you disagree.

Being together and sharing stories and events is the foundation of our relationships. However, when older people we know develop sensory losses, physical disabilities and cognitive losses, visitors are sometimes uncomfortable and not sure what to do.

Communication is still possible, but in different ways with the elderly. Touch and emotional tone is central. Your interest and pleasure, as you respond to and build on an older person's emotional stance, helps to create a positive experience for both of you. "Dementia is an unfortunately misleading word with a muddle of meanings. It creates a disabling fear which often cripples care for people experiencing cognitive change.

Aging does affect memory, as it does many other skills. But people do not lose their feelings, which are in fact often stronger, more expressive and direct. They do not lose their identity or their need for respect."

AGING AND COGNITIVE LOSS

Communications with the elderly has come a long way in understanding the complexity and diversity of the aging experience. We see this reflected on television, in film and advertising. There is a shift away from only looking at decline and illness to focusing more positively on wellness, prevention, intact abilities and possibilities.

Many nursing care professionals today now focus on an older person's strengths, rather than just their deficits. Older people in a variety of living situations are reinforcing this perspective as well. "Don't tell me what I can't do; tell me what I can do!"

As our elders live into old age, with increased likelihood of chronic illness, institutionalization becomes a necessary choice for some for the provision of care. Families and relationships will continue, though ways of connecting with one another may change.

Many of those who live in long-term care facilities have some form of dementia, such as Alzheimer's disease or vascular dementia from stroke. When we hear the word "dementia" or "Alzheimer's", the most commonly aroused feeling is fear!

Dementia is a general term used to describe a cluster of cognitive changes, most often in older adults. It refers to the deterioration of cognitive functions such as memory, speech and thought processes, and may be accompanied by changes in personality and behavior.

Alzheimer's disease, a degenerative brain disorder, is the most common form of dementia in adults. It can progress slowly or rapidly in a person. Whether it's the dreaded "A" word or "D" word, both are disabling labels that stigmatize a person. In subtle ways, the label creates social distance, i.e. those with dementia or Alzheimer's are not one of us.

Without an informed understanding of what cognitive change is all about, there are too many lost opportunities to engage, connect and have meaningful moments with people who are experiencing gaps in their memory.

This applies not only to family members, but to health care staff, volunteers and hired companions too. Even with cognitive changes, social capabilities are often still intact and require social experiences and opportunities for engagement.

Older people who begin to experience changes in their cognitive capacities which include short and long-term memory, judgment, insight, expressive and receptive language abilities continue to need to be connected to others in their social world, to feel useful and validated.

It is important that we try to make a conscious effort to understand their social world from their perspective, and reach out and communicate with them accordingly. "The elderly don't have a communication problem, we do!"

This manual will provide you with many different strategies for enhancing your connection and communication with your elderly. When cognition changes occur, connections and relationships with others become even more important in maintaining competencies and feelings of self-worth.

Our understanding of these interconnections creates a framework for our social our relationships. Put another way, how we view the older person with cognitive loss as a human being with a sense of self, or as confused and helpless affects how we, and they, respond.

Relationships with others provide the essential supports for personal wellbeing, whether in the community or in a nursing home. We need to provide as socially rich an environment as possible in all settings. Such an environment provides many opportunities for elders to experience and express a range of emotions, feel the warmth of someone's affection, be helpful to others, feel pleasure, share a humorous moment, and simply feel respected and accepted.

Many older people in nursing homes often complain of feeling helpless, isolated and bored. Paying attention to their perspective allows us visitors and caregivers alike to enrich their day-to-day life by offering as many opportunities for social engagement as we can.

Points to remember

- Maintaining our identity – our sense of competence is central to all of us, and this attribute continues as we age.
- Emotional memory persists for those with cognitive loss; feelings are often stronger, more expressive and direct.
- The older person needs to feel respected and validated throughout the visit.
- Ties of affection are affirmed by these visits.
- Observe and interpret behavior and use as clues for how to proceed.
- Use touch (if it is well-received) and nonverbal gestures to initiate movement.
- Anxiety and tension are easily communicated, and these feelings need to be acknowledged and eased where possible.
- Be attuned to emotional expression both theirs and yours.
- Change your expectations of visits as your relative's functioning undergoes changes.
- Acknowledge your relative's feelings and emotional state.
- Empathize and then move onward in a respectful manner.
- As language skills diminish for people with cognitive loss, place less emphasis on expecting answers to your questions.
- Their capacity to understand is usually greater than their ability to express themselves verbally. You can avoid frustration and feelings of inadequacy if you do not expect them to "perform". Instead, provide them with information.
- Elders who suffer from memory loss or speech impairment are often unable to respond to questions that require them to recall or describe events.
- Try to avoid asking information-seeking questions, such as "Tell me about your day?", "What did you have for lunch?" and so forth.
- Turn questions into statements about the here and now. For example, "It's good to see you today" or "I like your sweater/dress".
- Provide your relative with information such as, "Today is Friday, the day you attend the Shabbat program".
- Compliments are usually welcome and help create a comfortable mood.

- Providing links with the past, with what they enjoyed, can help shape your visits. For example, make an audiotape where you describe selected stories of their past.
- Activities can help generate pleasurable feelings. For example, try brushing their hair or massaging their hands with a perfumed cream. Listening to music, browsing through a magazine, sitting at the window, going with them to a program, are all activities that provide your elder with pleasure and stimulation without the need to make conversation.
- Look for experiences that will be relaxing and pleasurable for the older person.
- Create a tangible record of your times together, such as a visiting journal or taped conversation that can be referred to at other times by your relative, staff and friends. Reminders of these visits provide support and reassurance.
- The process of reflecting on past visits creates positive feelings for the older person.
- As in all of life, a sense of humor is often the best tool to help us through uncomfortable moments. Humor can open the door to lost emotions, simple understandings, and even some insight.
- Acknowledge to yourself that your presence is a comfort to your elder, and convey the message that you are a part of their life.

In trying to understand the behaviors and feelings of elders who have varying degrees of cognitive loss, it is vital to focus on their frame of reference in interpreting and giving meaning to events in their life. Put another way, try to imagine being in their shoes! Their unique behaviors can be seen as attempts to cope with daily situations, including trying to solve problems they are experiencing.

Elders with cognitive loss try to make sense of their experiences they have an emotional reaction, the meaning of behaviors and feelings they seek solace when upset, meaning when confused, and self-esteem when dignity is compromised.

What is often termed “challenging behaviors” by health care professionals should instead be viewed as signs of the person trying to solve a problem, of making sense of an experience with insufficient information.

THROUGH OUR EYES

All of us have our own “lens” through which we observe, interpret and give meaning to things. This continues throughout our lives, and is especially important to understand when a person is experiencing cognitive changes.

The person’s preferred view is their frame of reference, their lens, which is used to interpret and give meaning to events in their lives, and to the ordinary day-to-day occurrences that form the texture of daily life in a long-term care facility.

The more we understand the person’s preferred view and sense of self, the more we are able to use this knowledge to guide family members and staff in their approach and ways of communicating.

All of us have many social roles, for example, daughter, wife, employee and caregiver. Older people, in particular, need validation as valued members of a community or a living unit in a nursing home.

MEANINGFUL SOCIAL ROLES

Some of their “roles” have been taken away from them, so we need to provide them with meaningful social roles, such as “storyteller”, “helper” or “good listener”, which tap into their humor, creative imagination and social skills.

Many older people continue to want to help others and feel useful. We need to think about how best to facilitate those meaningful experiences. Memories of their past, when they were active members of the community, are usually more preserved and can be rekindled by sharing stories, looking at old photos together, and acknowledging (or disputing!) their sage advice show them that you continue to value their opinions.

Visiting in its most basic sense is about “being present”. What makes visiting difficult for some is the personal meaning and expectations that we, the visitors, bring to the visiting experience. Visiting an elder in an institution involves an understanding and appreciation of interconnecting variables you, your elder and the institution.

Visiting your relative, friend or resident in a long-term care facility means something very different than visiting, for example, a friend in their home or acute care hospital. The long-term care institution is their new home and most likely will be their “home” for life. The elder’s health care needs exceed those which you and relatives are able to meet.

DIFFICULTIES

Difficulties can arise in visiting with your relative. For some, difficulties may be overcome by discovering new ways of connecting that provide a meaningful experience for both of you. In assisting you to determine if there are areas where visiting is difficult, consider ways in which you can help the situation and any hard feelings you may have had.

Visiting will remain difficult when it does not meet our expectations. While visiting our elders will no doubt remain a creative challenge for us individually and collectively, developing realistic expectations will enable us to take up the challenge to be informed and involved participants in our elders’ lives. Visiting offers us meaning when it helps us feel better about ourselves and provides comfort, support and continuity in our relative’s life.

Meaningful visiting takes place when the time we spend is not only fulfilling a perceived familial obligation, but is a socially and emotionally connected time.

FAMILY

The family caregiver role continues into the institution. As social beings, we rely on one another and especially look to our family members to care for and about us. Perhaps at no other time is the social and emotional bond with our relative as important as in their elder years when our visits maintain and sustain their connectedness to the community, our families and ourselves.

Ongoing interest and involvement in our elder's life in an institution can aid them in accepting their losses of health and former lifestyle, and in validating their social competencies. Moreover, coming to terms with our relative's mortality involves both an acceptance and understanding of their illness and the aging process itself.

Being an active member in this process can provide an opportunity for you and your relative to resolve differences, heal old wounds and pave the way for a fuller, deeper and more rewarding relationship.

Visiting helps emotionally sustain our elder's self-esteem and personhood throughout their life in an institution. Grief and loss generate powerful emotions in all of us. Losses can be physically related, as in reduced mobility, or social and emotional such as loss of "role" as a worker, friend or spouse.

There are also ambiguous losses, such as when your relative has lost so many capabilities that you feel the person you knew is no longer present, and yet they still are (see the vignette, "Family drifting away").

Anticipatory losses are those that have yet to happen, so you think and worry about what is going to happen in the future and how you will deal with those losses.

GRIEF AND LOSS

It is okay to grieve losses and at the same time find meaning in the ways you support your relative's life in a long-term care facility. Letting your relative know that they are an important person in your life and that you think about what they have accomplished in their lifetime, will help validate their sense of having an impact on others.

Remember, grieving and mourning losses experienced by your relative is a normal part of life. Acknowledging their feelings and expressions of anger, frustration, anxiety and fearfulness are important emotions to be valued and listened to.

Similarly, acknowledging your own feelings of sadness, loss and guilt are important in gaining a realistic perspective and not being overcome by misplaced feelings of guilt. All family members have their own "comfort zone" in how they cope with losses, so it is important to do what feels right for you and not to judge others.

HOW TO CONVEY SAD NEWS

Many family members are uncertain about how best to convey news of a family death to a frail, elderly relative. Family members are often apprehensive that the shock of such news will be overwhelming to their relative, and they want to shield and protect them from that and from the emotional distress. As well, they may reason that because of their relative's short-term memory loss, they might forget the sad news and inquire on each subsequent visit.

Losses are part of life and older people living in nursing homes have experienced their share of social, physical and relational losses. They are also aware and understand their social situation, and in most instances show remarkable resiliency. They are sensitive to mood and interpersonal dynamics and they can sense if a visitor is sad or upset, so include your relative in the sharing of sad times as well as happy ones.

You need only share the sad news with a brief explanation that you are comfortable with and that resonates with the truth. It is best not to mislead or tell an untruth, as feelings of distrust, or being left out, can be engendered.

Sharing memories and stories is a way to support your relative through such sad times. Include them in the cultural rituals that are important to you.

Improvising and creating a meditative place in a long-term care facility, where you can bring your relative, can be helpful to both of you to honor the one who has died. Consult with staff for assistance. They can help with problem solving and also support your way of handling this situation.

CONVERSATIONS

Conversations, dialogue, and even arguments are at the core of our relationships with others. When conversing with a person who is experiencing cognitive changes, we need to be particularly sensitive to how we respond when they have word-finding difficulties.

Generally, the older person continues to understand far more than they can express in words, so it's important to try and understand their thoughts, and to listen for the deeper meaning of what they are trying to express by words or body language.

We can try reframing a statement, asking if that is what they are thinking of and wanting to tell us. Knowing them, and the details of their personal past, often gives us clues to their responses.

Take note of their emotional state, it is central to understanding their behaviors and responses. If they are feeling sad or frustrated, we should acknowledge that. They will feel reassured and know that someone is listening to them. It is often helpful to try putting into words what we think is on their mind, and see how they respond.

PRACTICING “INDIRECT REPAIR”

If your relative often has difficulty finding the right word to say in conversation, you can help lessen their frustration by gently guessing and picking up on clues from knowing their past and preferences.

This technique is known as “indirect repair”. The more you know about their current life and what is important to them, the more able you’ll be in helping them express their thoughts. Keep trying, you will get a big smile and a sigh of relief when you’ve put into words the thoughts they were struggling to express.

Remember, your relative usually knows what they want to tell you, they just aren’t able to find the right words like they used to.

How to enhance communication:

- Create a comfortable emotional ambience.
- The emotional mood sets the tone of the visit.
- Show respect in everything you say or do.
- Place yourself at eye level with your elder.
- Be receptive to changes in mood or behavior during the visit, and adjust what you do and say accordingly.
- Acknowledge the feelings you observe, provide reassurance, and try to engage in an activity that will provide comfort, e.g. storytelling, singing.
- Be attuned to your relative’s preferences for social space. Some people prefer small, intimate gatherings; others like to be on the periphery of a social activity or area.
- Your demeanor - facial expressions and posture is communicated easily.
- By touching and gesturing to animate your talk, you communicate an interest in your relative.
- For example, smile and touch their hair as you say, “Your hair looks pretty”.
- Use your normal conversational tone in speaking.
- Be patient. You need to allow time for your relative to absorb, understand and think about what you have said. They need to be given time to respond in a manner that suits their capabilities.
- Restate your message if it is not understood the first time. Aim for concise, straight-forward sentences.
- Make a reasoned guess at what their response or understanding might be, and see if they concur by shaking their head or nodding approval.
- Acknowledging losses together reaffirms the bonds of affection and family ties. Sharing sadness over the death of a loved one is an important way to be together.
- Keep in mind that it is not important to fill every moment with words and conversation.
- Depending upon your elder’s present level of health and abilities, becoming comfortable with silences, and just being with your loved one, may be the most reasonable and achievable goal for you.

COMMUNICATION TIPS

- Don't ask a pointed question such as, "Mom, do you know who I am?" Instead say, "Hi Mom, it's your daughter Shirley."
- If Dad talks about someone who died 20 years ago, don't say, "Dad, Bob's been dead for 20 years!" Instead say, "I guess you're thinking about Bob. He was very special to you."
- When you read anxiety, confusion or fear on your parent's face, respond with a comforting, soothing voice and put an arm around their shoulder. Consider going for a walk if he or she is able. This often helps relieve anxiety and gives them a change of scenery.

If Mom is having difficulty speaking, try to connect in a different way. For example:

- Comb her hair
- Massage her hands with lotion
- Paint her nails
- Give her a hug. Make her feel appreciated and validated as a person with a lifetime of experiences.

Reminiscing can have a significant and positive effect on our elder. It affords them the opportunity to understand and appreciate aspects and events of their life more fully. Moreover, it allows them to see their present life with renewed meaning and continuity, grounded in present day circumstances and events. Reminiscing is also a way to enhance your relationship with your relative.

LIFE STORIES

Sharing life stories is a valuable way to spend time together. Encourage them to talk about their perceptions and recollections. As relatives recount their experiences, you may gain more information and insights about their life and role in your extended family. Listening to their stories affirms their present feelings of self worth.

Reminiscence allows relatives and residents to give you something that is unique and part of them self. By encouraging these activities and reflections, you continue to honor the wholeness of their life.

CHANGE IN LOCATION

- If possible, take the opportunity to have resident explore the facility or go outdoors.
- Consider a location that allows privacy to visit, and minimizes noise and distraction.
- Arrange what is manageable and works in your schedule. The visit will be most enjoyable if not rushed.
- No matter what your schedule, it's important to keep relatives and residents informed as to when you will visit and how long you will be staying.

Consistency in visiting helps establish a visiting routine for and reduces their anxiety or uncertainty about when you'll be dropping by next.

Be truthful in what you communicate to your resident “I’ll be back in a few days” or “I’ll see you on Sunday”. Be brief and provide reassurance of your caring.

INTERGENERATIONAL VISITS

Connections with family contribute significantly to an elder’s sense of wellbeing. Younger family members should be encouraged to maintain connections with their elder relative.

Prolonged absences of younger family members may be interpreted by the elder as abandonment and punishment. At a time when they need to feel a part of their family, they may instead feel cut off emotionally, physically and socially from the lives of younger family members.

Young children can quickly learn to respect, care for, and build a connection with their elderly family members.

Unlike adults, children freely ask questions and are curious about the environment they find themselves in. Being honest and open in your communication with your children shows respect for them, their feelings and their capacity to contribute to the wellbeing of their relative.

Children like to help and can participate in any number of activities with their elderly relative. Many of the activities/ ideas listed previously can be shared with children. Your relative will also benefit from the simple joy of watching a child play, and a child’s endless supply of hugs and kisses.

GIFT GIVING

Selecting a gift for someone in an institution can be challenging as rooms are small and their needs can often change. Below are a few suggestions:

- Books and reading material
- Clothing that encourages independence and ease in dressing (e.g. tracksuits or adaptive clothing)
- Slippers with a good tread
- Accessories, such as scarves
- Hand lotions
- Photos in a picture frame/album
- Calendar
- A gift related to a past interest/hobby
- Plants or bulbs to grow by the window
- Magazine subscription
- Music tapes, CDs or videos
- Food and treats that take into account special dietary needs
- Give your relative permission to ‘give away’ some of the gifts given to them. Candies, cookies or fruit provide your relative with an opportunity to give to others, thus enhancing their self-esteem.

THE SENSES

Try to use a variety of senses to increase the elderly response. Different scents, sounds, touches, sights and tastes will stimulate increased awareness. It is important to present one sense at a time to avoid overloading your relative's sensory capabilities.

DAY TO DAY CHANGES

Each visit will change from day to day and plans are subject to changing. Residents that you spoke with yesterday may not feel like talking today or residents may not be feeling well or residents that normally never want to talk will stop you and want to talk at length about what happened to him that day.

It is important to be open to unexpected changes and to go with the flow. Gradually you will start to get to know more and more of the residents because you will meet them in the halls, hold the doors open for them, help push them down to their room, etc. Try to never be too busy to stop and help out in this way.

You will start to get familiar with residents that the Activity Director originally helped you pick out, because you will be attempting to visit them each week. As your group grows, your ministry will begin to grow.

You can meet in a predetermined meeting room or place, talk for a few minutes, and then go in different directions to visit with various individual residents. The ultimate goal of a chaplain is to form friendships with these individuals and you should be visiting the same resident week after week.

It will be helpful, to have a topic for discussion at the beginning of each visit. You should bring a specific topic (newspaper, article, photos) or come up with other ideas to discuss. You can also discuss how your visits went the week before.

SUMMARY

This section of study is guidelines. They are things learned over years of trial and error, and they will probably work for most situations. However, you will have to try things that will work for your own personal ministry. Much of nursing home facility victory is trial and error for each individual chaplain. You may have to make some adjustments as necessary. Be open to changes.

Nursing home facilities are operated differently and some may have special restrictions they may put on their programs, such as visiting hours, or group size. You will have to adjust the program for their rules, or go to a different nursing home. Never try to go against the rules of the nursing home facility.

No matter how all the particulars work out in your situation, the goal is to visit residents and to be open to what they have to share with you. You can work out as you go how best to accomplish that goal and how you can best get other volunteers involved

A chaplain provides a friendly visitor, counselor, and a chaplain to meet the needs of those in the respective homes. In addition, chaplains and volunteers provide much needed worship services

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and brings together diverse people who share one common concern, to serve the sick and the elderly.

Many ministries have teams that visit their own parishioners who are confined in long-term care centers. But not many maintain a ministry of presence in so many different care centers as which is there to serve the needs of ALL the residents and members of the staff and administration as well. It is the mission of Chaplain Fellowship Ministries International Inc. to change that.

Our services are free and open to all. We respect the dignity of the individual and serve each person regardless of race or ethnic origin, social or economic status.

Persons of any religious background or none at all, are welcome to participate. No one is ever excluded. Our concern is for the spiritual and emotional well-being of all confined seniors.

A nursing home care facility chaplain is available to provide counseling to residents and their families and staff members of long-term care centers, who may be concerned about depression, terminal illness, bereavement, or other significant personal losses affecting their emotional health. Chaplains should also be available to conduct memorial services and funerals when necessary.

NOTES

CHAPTER 10

ADDRESSING TOPICS

PREPAREING FOR ENTERING A NURSING HOMEA chaplain is often asked by nursing staff or family members to help “prepare” a person for entering a nursing care facility and/or they will find themselves ministering to someone who has no understanding about why they are there or has no wish or want to be there. This chapter will help the chaplain in assisting when questions arise.

For many families, the decision to place an elderly person, disabled person or terminally ill person into a nursing care facility may be one of the hardest decisions you will ever make. It is a challenge for most families.

Family members should try to ease a loved one into the change. Although families often go to great lengths to keep aged loved ones at home, they may not be able to provide the best physical and emotional care. And, even if they are able, this type of intense caring may cause undue stress within the family. When home care is no longer adequate, a decision must be made concerning the best alternative arrangement for meeting personal and healthcare needs.

It's advisable to take the necessary amount of time “beforehand” to ensure a smooth transition for your loved one from his/her own home to a nursing care facility.

This decision should be made carefully and thoughtfully, with as much consideration and respect as possible with your loved one. Often there isn't enough notice to evaluate all of the available information, so it's helpful to have made as many preparations as possible well in advance.

The transition can be traumatic for a new resident. The stress of adapting to a new environment can be great, and can trigger illness or a depressive episode.

It is vital for everyone's well-being to decide early on the best new arrangement, one that meets both your family's needs and those of your loved one. And, then to prepare for taking that decision.

It's not easy, nor wise, to attempt making such an important decision completely on your own. Prior to you and your family making this difficult choice, a healthcare professional should assess the level of care that the person needs and determine what combination of services is required.

They can begin the process by asking themselves what your loved one wants. This important question is overlooked far too often. Older people whose mental functioning is still fairly good should, by all means, be invited to participate in the decision. Many older people are attached to the familiar surroundings of their own homes and take a sudden turn for the worse if they think they're being forced to leave.

Loved ones will adjust much better to the trauma of leaving home if his or her feelings and wishes have been taken into account and respected.

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With the elderly, it may be that they are capable of living somewhat independently, yet have become incapable of managing all of their affairs, and have needs you and other family members are unable to meet.

For those who do not require comprehensive, full-time nursing care, several alternatives are available, including assisted living in a nursing home.

If a loved one is very ill or mentally confused, family members, along with physician's advice, will be required to make decisions on his or her behalf.

When dealing with a loved one, being as straightforward as possible may lessen the possibility of confusion or resentment in the future. Explain the decision and make promises that you can keep. It's important to let him or her know that you and others will visit as often as you're able. And, if you say you'll visit on a regular basis, do so. One way to make this promise easier to keep is to choose a facility that's within reasonable reach of family members.

The frequency of visits is an individual decision, but keep in mind that the presence of family members and friends greatly helps to create a more personal atmosphere in the nursing home and goes a long way toward minimizing the initial stress of moving into the facility. Family visits offer reassurance that someone still cares. In fact, those residents whose families are involved in their care usually have higher morale.

In addition, the transition will be smoother if the resident is allowed to take some of his or her furnishings and prized possessions along. A favorite chair or painting in the room at a nursing facility will help a resident feel more at home.

As the decision-making process progresses, family members need to be aware of and deal with their own feelings. Deciding to place a loved one in a nursing home will be stressful for them and their family. Be aware that you may feel anger, resentment and especially guilt. Such feelings are normal during a family member's transition to a nursing home, and you should openly deal with:

Helplessness -- As you watch a loved one grow frail, you may feel frustrated because you are unable to help. You also may experience the anguish of realizing that their time with you is limited.

Guilt -- You may think you haven't been understanding enough or patient enough with your loved one. And, your siblings or other relatives -- who may not have had to deal with the day-to-day difficulties as you have -- may accuse you of callousness.

Fear of Aging -- This is often a source of anger as we experience the realization that we all will face the same changes someday.

Anger -- Often directed at the loved one for not having taken better care of himself or herself, responsibility if assigned to the person for his or her frail condition.

Resentment -- You may feel that your loved one has become too much of a drain on your time, energy and financial resources. And, you may choose, consciously or unconsciously, to act on this feeling by avoiding visits.

It can be frustrating when someone you've had as a source of strength has become dependent upon you. Understanding your feelings about the situation will help you to be more supportive during this difficult time.

LIFE STAGES

Each stage of life has specific tasks of development that lead to a restructuring of the individual's personality organization. The Infancy stage involves Birth, The most important developmental functions of this stage are the integration of breathing, elimination, and feeding and the initial consolidation of motility, sensory perceptions, and behavior patterns. Birth and Death are just examples of events that occur during a stage of the Life Cycle.

- The Early Years Guide (0-5 years)
- The School Age Guide (6-13 years)
- The Young Adult Guide (14-21 years)
- The Adult Guide (21 years and older)

THE THIRD AGE

Scientific advances and the consequent progress of medicine have made a decisive contribution in recent decades to prolonging the average duration of human life. The term "third age" now embraces a large segment of the world's population: people who have retired from active employment, yet who still have great inner resources and are still able to contribute to the common good.

To this huge throng of "young old" (as they are called by the new categories of old age defined by demographers, i.e. those aged between 65 and 70) is added a so-called fourth age, that of the "oldest old" (those over 75), whose ranks are likewise destined to become ever more numerous.

The prolongation of average life expectancy and the sometimes dramatic decrease in the birth rate, has given rise to an unprecedented demographic transition: the age pyramid that existed less than half a century ago has literally been turned upside down.

The number of older people is constantly increasing, while that of the young is constantly decreasing. Starting out from the countries of the northern hemisphere in the 1960s, the phenomenon has now spread to those of the southern hemisphere, where the ageing process is even more rapid.

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This kind of “silent revolution” goes far beyond the demographic data: it poses social, economic, cultural, psychological and spiritual problems of a magnitude which has for some time been a matter of concern to the international Community.

An International Plan of Action on Ageing was formulated at the World Assembly on Ageing held by the United Nations in Vienna, Austria, from 26 July to 6 August 1982, and remains to this day an international point of reference.

More recent studies have led to the definition of eighteen United Nations Principles for Older Persons (grouped under five headings: independence, participation, care, self-fulfillment and dignity) and to the decision to dedicate an annual World Day to older people, to be celebrated on 1st October each year.

The United Nations resolution, declaring 1999 the International Year of Older Persons, and the choice of its theme “Towards a Society for All Ages”, are a further confirmation of this interest.

A society for all ages is a society which, far from caricaturing older people as retired and infirm, considers them on the contrary as agents and beneficiaries of development. A society for all ages is, therefore, a multigenerational society committed to creating the conditions of life able to fulfill the great potential that older people still have.

Inspired by a conviction by people worldwide that older people still have a lot to say and a lot to give to the life of society, their dignity and fundamental rights should be respected by individuals, families, associations, governments and international organizations, each according to its own competencies and duties and in conformity with the very important principle of subsidiarity.

Only in this way can older people be enabled to enjoy ever more human living conditions and play their indispensable role in a society undergoing a rapid and continuous process of economic and cultural change.

Only in this way, can concerted action be taken to exert influence on the social, economic and educational systems in such a way as to provide all citizens, without discrimination, with the necessary resources to satisfy old and new needs, to ensure the effective protection of rights, and to restore grounds for trust and hope and a sense of belonging to all those excluded from active participation in the human community.

The Church's attention and commitment to older people are nothing new and most churches have offered pastoral care to older people in the most varied circumstances over the centuries.

Christians have embraced their needs; it has given rise to the most varied forms of apostolate at the service of older people, especially thanks to the initiative and concern of religious congregations and lay associations.

The Church's teaching, far from considering the question as a mere problem of assistance and charity, has always reaffirmed the primary importance of recognizing and fostering the intrinsic value of persons of all ages.

Christian teachings remind everyone of the need to ensure that the human and spiritual riches, the reserves of experience and wisdom accumulated in the course of entire lives, be not lost.

It has to be recognized that the current situation concerning the elderly is unprecedented in many respects. With the current number of elderly in this country many churches have revised programs for pastoral care of older people in the third and fourth ages.

New forms and methods, more consistent with the needs and spiritual aspirations of older people, need to be sought; new pastoral plans rooted in the defense of life, of its meaning and destiny, need to be formulated.

These are essential conditions for encouraging older people to make their own contribution to the Church and helping them to derive particular spiritual enrichment from their active participation in the life of the ecclesial community.

MEANING AND VALUE OF OLD AGE

People live longer and enjoy better health than in the past. They are also able to develop interests made possible by higher levels of education. Old age is no longer synonymous with dependence on others or a diminished quality of life. But all this seems not enough to dislodge a negative image of old age or encourage a positive acceptance of a period of life in which many of our social groups see nothing but an unavoidable and burdensome decline.

The perception of old age as a period of decline, in which human and social inadequacy is taken for granted, is in fact, very widespread today. But this is a stereotype. It does not take account of a condition that is in practice far more diversified, because older people are not a homogeneous human group and old age is experienced in very different ways.

There are some elderly people who are capable of grasping the significance that old age has in the context of human existence, and who confront it not only with serenity and dignity, but as a time of life which offers them new opportunities for growth and commitment.

But there are others, to feel old age is a traumatic experience, and who react to their own ageing with attitudes ranging from passive resignation to rebellion, rejection and despair. They are persons who become locked into themselves and self-marginalized, thus accelerating the process of their own physical and mental deterioration.

It may be declared that the aspects of the third and fourth stages of life are as diverse and varied as older people themselves, and that each of us prepares for old age, and the way we experience it, in the course of our own life.

In this sense, old age grows with us and the quality of our old age will especially depend on our capacity to grasp its meaning and appreciate its value both at the purely human level and at the level of faith.

Therefore, we need to situate old age in the context of a precise providential scheme of God who is love. We need to accept it as a stage in the journey by which Christ leads us to the Father's house (Jn 14:2). Only in the light of the faith, strengthened by the hope which does not deceive (cf. Rom 5:5), shall we be able to accept old age in a truly Christian way both as a gift and a task.

That is the secret of the youthfulness of spirit, which we can continue to cultivate in spite of the passing of years. Linda, a woman who lived to the age of 106, left us a magnificent testimony of this. On her 101st birthday, she confided to a friend: "I'm now 101 years old, but I'm strong, you know. Physically I have some disabilities, but spiritually there is nothing I can't do. I don't let physical impediments stand in the way. I pay no attention to them. I don't suffer old age, because I ignore it: it goes ahead on its own, but I pay no heed to it. The only way to live well in old age is to live it in God".

To correct the current, largely negative image of old age is therefore a cultural and educational task which ought to involve all generations. We have a responsibility towards older people today: we need to help them to grasp the sense of their age, to appreciate its resources, and to overcome the temptation to reject it, and so succumb to self-isolation, resignation and a feeling of uselessness and despair.

We also have a responsibility towards future generations: that of preparing a human, social and spiritual context in which each person may live this period of life with dignity and fullness. Pope John Paul II affirmed: "Life is a gift of God to man who is created out of love in the image and likeness of God.

This understanding of the sacred dignity of the human person leads to the appreciation of every stage of life. It is a question of consistency and justice. It is impossible to truly value the life of an older person if the life of a child is not valued from the moment of its conception. No one knows where we might arrive, if life is no longer respected as something inalienable and sacred".

The multigenerational society we aspire to shall only become an enduring reality if it be based on respect for life in all its phases. The presence of so many older persons in the modern world needs to be recognized as a gift, a new human and spiritual potential for enrichment.

It is a sign of the times which, if fully accepted and understood, may help contemporary men and women to rediscover the fundamental meaning of life, which far transcends the purely contingent meanings attributed to it by market forces, by the State and by the prevailing mentality.

The contribution that older people, by their experience, can make to the process of making our society and culture more human is particularly valuable.

Dis-interestedness: The prevailing culture of our time measures the value of our actions according to criteria of efficiency and material success, which ignore the dimension of disinterestedness: of giving something, or giving ourselves, without any thought of a return.

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Older people, who have time on their hands, may recall the attention of an over-busy society to the need to break down the barriers of an indifference that debases, discourages and stifles altruistic impulses.

Memory: The younger generations are losing a sense of history and consequently the sense of their own identity. A society that minimizes the sense of history fails in its responsibility to educate young people.

A society that ignores the past more easily runs the risk of repeating its errors. The loss of an historical sense is also attributable to a system of life that has marginalized and isolated older people, and that hampers dialogue between the generations.

Experience: Today we live in a world in which the responses of science and technology seem to have supplanted the value of the experience accumulated by older people in the course of their whole lives. This kind of cultural barrier should not discourage people of the third and fourth ages, since they still have a lot to say to the young generations and to share with them.

Inter-dependence: No man is an island. But growing individualism and self-seeking are obscuring this truth. Older people, in their search for companionship, challenge a society in which the weaker are often abandoned; they draw attention to the social nature of man and to the need to repair the fabric of interpersonal and social relationships.

Vision of life: Our life is dominated by haste, by agitation, and frequently by neurosis. It is a distracted life, a life in which the fundamental questions about the vocation, dignity and destiny of man are forgotten.

The third stage is also the age of simplicity and contemplation. The affective, moral and religious values embodied by older people are an indispensable resource for fostering the harmony of society, of the family and of the individual. These values include a sense of responsibility, faith in God, friendship, disinterest in power, prudence, patience, wisdom, and a deep inner conviction of the need to respect the creation and foster peace. Older people understand the superiority of “being” over “having”. Human societies would be better if they learn to benefit from knowledge of old age.

NOTE

CHAPTER 11

DEATH AND DYING

One of the most used words in any language when someone dies is why. Why do people get sick, why did the accident happen? Why are there earthquakes that destroy entire cities? Why do hurricanes happen? Why do people have to work so hard just to have enough money to barely feed their families? Subconsciously, we probably ask ourselves questions like these quite often. But we're so busy living our lives we rarely stop and wonder WHY?

Reality is one of the most sobering emotions we can have and during the grief process it has the tendency to hit us hard. And then something else happens, our parents get divorced, the 3 year old gets abducted and murdered or a relative gets cancer.

That's reality but we can subconsciously revert back into denial. That is, until another tragedy hits, another incongruence. Then we're likely to think, something isn't right here. Something is really, really wrong. This isn't how life's supposed to be! So, WHY do bad things happen? WHY isn't this world a better place?

There is an answer to the WHY question, found in the Bible. But it's not an answer that most people like to hear: the world is the way it is because it's the world that we, in a sense, have asked for. Sound strange?

What or who could make this world different than the way it is? What or who could guarantee that life is pain-free, for everyone, all the time? God could. God could accomplish that. But he doesn't. At least not right now. And we're angry with him as a result. We say, "God can't be all-powerful and all-loving. If he were, this world wouldn't be the way it is!"

We say this hoping that God will then change his position on the matter. Our hope is that putting a guilt trip on him will make him change the way he's doing things. But he doesn't seem to budge. WHY doesn't he?

God doesn't budge; he doesn't change things right now because he's giving us what we asked for: a world where we get to treat him as though he is absent and unnecessary.

Remember the story of Adam and Eve? They ate the "forbidden fruit." That fruit was the idea that they could ignore what God said or gave them, and strike out on life apart from God.

For Adam and Eve hoped they could become like God, without God. They consumed the notion that there was something more valuable in existence than God himself, something more valuable than having a personal relationship with God. And this world system with all of its faults came as a result of the choice they made.

Their story is the story of all of us, isn't it? Who hasn't said, if not audibly at least in their hearts God, I think I can do this without you. I'll just go this one alone. But thanks for the offer.

We've all tried to make life work without God. Why do we do that? Probably because we've all bought the notion that there's something more valuable, more important, than God.

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For different people it's different things, but the mindset is the same: God isn't what's most important in life. In fact, I'd just as soon do it without him altogether. What is God's response to that?

He allows it. Many people experience the painful results of others' or their own choices that run contrary to God's ways, murder, sexual abuse, greed, lying/fraud, slander, adultery, kidnapping, etc. All of these can be explained by people who have refused to give God access and influence over their lives. They are going about their lives as they see fit, and they and others suffer.

What's God view on all of this? God could rightly be viewed as leaning forward, compassionate, hoping we will turn to him so that he can bring real life to us. Jesus said, "Come to me, all who are weary and heavy-laden, and I will give you rest." But not all are willing to go to him.

Jesus commented on this when he said: "O Jerusalem, Jerusalem, you who kill the prophets and stone those sent to you, how often I have longed to gather your children together, as a hen gathers her chicks under her wings, but you were not willing." Again, Jesus brings the issue back to our relationship with him. "I am the light of the world. He who follows me will not walk in darkness, but will have the light of life."

But what about when life is unfair? What about those horrible circumstances that hit us in life, caused by someone other than ourselves? When we are feeling victimized, it's useful to realize that God himself endured horrendous treatment from others. God more than understands what you are going through.

There is nothing in life that could be more painful than what Jesus endured on our behalf, when he was deserted by his friends, ridiculed by those who would not believe in him, beaten and tortured before his crucifixion, then nailed to a cross, in shameful public display, dying of slow suffocation.

He created us, yet allowed humanity the freedom to do this, to fulfill Scripture and to set us free from our sin. This was no surprise to Jesus. He was aware of what was coming, foreknowing all the details, all the pain, all the humiliation.

"And as Jesus was going up to Jerusalem, he took the twelve disciples aside, and on the way he said to them, 'Behold, we are going up to Jerusalem, and the Son of man will be delivered to the chief priests and scribes, and they will condemn him to death, and deliver him to the Gentiles to be mocked and scourged and crucified, and he will be raised on the third day.'"

Imagine knowing something that awful was going to happen to you. Jesus understands emotional and psychological anguish. The night that Jesus knew they would arrest him, he went to pray, but took some friends with him. "And taking with him Peter and the two sons of Zebedee, he began to be sorrowful and troubled. Then he said to them, 'my soul is very sorrowful, even to death; remain here and watch (keep awake) with me.'

And going a little farther he fell on his face and prayed, 'My Father, if it be possible, let this cup pass from me; nevertheless, not as I will but as thou wills.'

Though Jesus confided in his three friends, they didn't understand the depth of his torment, and when Jesus returned from prayer he found them asleep. Jesus understands what it's like going through pain and extreme sadness alone.

Here it is summarized, as John describes in his gospel: "He was in the world, and the world was made through him, yet the world knew him not. He came to his own home, and his own people received him not. But to all who received him, who believed in his name, he gave power to become children of God." "For God sent the Son into the world, not to condemn the world, but that the world might be saved through him. For God so loved the world that he gave his only Son, that whoever believes in him should not perish but have eternal life."

There is no question that there is pain and intense suffering in this world. Some of it is explained by selfish, hateful actions on the part of others. Some of it defies an explanation in this life. But God offers us himself. God gives us the knowledge that he has endured also, and is aware of our pain and needs. Jesus said to his disciples, "Peace I leave with you; my peace I give to you; not as the world gives do I give to you. Let not your hearts be troubled, neither let them be afraid."

There is ample reason to be afraid, troubled, but God can give us his peace, which is greater than the problem before us. He is after all, God, the Creator. The one who has always existed, The one who created a universe on the backstroke.

Even in his power, he knows us intimately, even the smallest, insignificant details. And if we will trust him with our lives, relying on him, though we encounter difficulties, he will hold us securely. Jesus said, "These things I have spoken to you, so that in me you may have peace. There is tribulation throughout the world, but take courage; I have overcome the world." He went through our ultimate threat, death and overcame it. He can take us through the difficult circumstances of this life, and then bring us into eternal life, if we will trust him.

We can either go through this life with God or without him. Jesus prayed, "O righteous Father, although the world has not known you, yet I have known you; and these have known that you sent me; and I have made your name known to them, and will make it known, so that the love with which you loved me may be in them, and I in them."

To find out how to begin a relationship with God, please see Knowing God Personally.

- (1) Matthew 11:28
- (2) Matthew 23:37
- (3) John 8:12
- (4) Matthew 20:17-19
- (5) Matthew 26:37-39
- (6) John 1:10-12
- (7) John 3:17,16
- (8) John 14:27
- (9) John 16:33
- (10) John 17:25, 26

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We must explore the ways of dealing with death and dying so that we can serve both the caregiver and the dying person practically and spiritually. We also need avenues to work within ourselves and with the dying that are basically helpful and pragmatic, often very ordinary and essentially practical.

Dying is a natural event. But there are things that we can do; ways we can be that help the true nature of dying come forth. These "ways" are expressed in terms such as compassion, tolerance, ease, kindness, humor, warmth, wisdom, authenticity, mindfulness, stability, openness, and concentration. It takes a person who is psychologically and spiritually mature who carry these qualities to express these qualities when they are helping someone through the process of death.

These qualities depend on culture or knowledge of different cultures and the way that particular culture sees' death. There are things that we can to open these sensibilities within professional and volunteer care givers, as well as in our communities to help family and friends have the internal means to assist with suffering and dying in a compassionate and skillful manner.

Death is not an individual. The actual motion process of dying is a drama that will be observed by others and participated in by others and we leave to others a legacy of how we have experienced our own death.

The importance in the way we leave this legacy effects everyone's perceptions of dying and death, and how these perceptions shape our experience of living and dying depends on our actions and perceptions to the death process.

For the care giver of a dying individual, many times the care givers are actually working with many of the same issues as those who are immediately dying. The knowledge of the inevitability of our own deaths has called many of us to do this work. We all feel the need to become familiar with this profound experience of living. The issue of our own dying and death and how we have worked with it effects and shapes the work we do as care givers.

There is a great need for support concerning personal issues care givers have in relation to working with dying people and their feelings about death, suffering and loss. Setting up support systems that include care givers and dying people is an essential element in keeping alive the communication and learning process around death and dying for those who are in service to the dying and those who are aware that they are facing death in the future.

There is a need to develop ways to teach care givers and dying people about how to have a realistic, open minded approach to dying. However, since dying is an individual act for the person dying it also becomes an individual process for the care giver.

There is no how-to book written on how to die or how to help the one who is dying and for the persons who care for the dying, both the spiritual and practical aspects of death and dying must be looked at from a contemplative perspective.

HOW WE CAN IMPROVE THE EXPERIENCE OF DYING

Develop a support system for:

- Care givers
- Dying people
- Professionals (nurses, hospice)
- Family members

This system should be based in a contemplative perspective that offers spiritual care. Training in contemplative approaches and practices is important on a professional level, where dying and death are encountered on a daily basis, and the pressure of work and "patient load" is great.

We should research and identify existing groups and institutions that are doing, have done or can do this type of work and infuse them with support to deepen and expand their efforts. This would include Christian groups and congregations, elder community volunteers, and hospice groups.

Training in this type of work needs to be developed on a cultural, non-denominational and spiritual level prior to any type of system or program is put into place. An inter-cultural and inter-religious group should be formed that approaches the challenge of creating a culturally relevant, flexible, and effective training program and care giving program in spiritual care for the dying that are appropriate for different cultures and religions.

Programs for the community should be created. This type of program can deepen relationships in the community. It can deepen inquiry; make genuine and effective support more available. It can help alleviate care giving families who are under stress and pressure around the situation of dying, take some of the work load off of the professional community, and put dying where it most often should be, i.e., in the home and community with loved ones.

Systems already in place contain projects using a contemplative and spiritual basis supported, created and evaluated as to their effectiveness for: the dying person, the family, the care givers and physicians.

ELDERLY, ILLNESS and DYING

The main concerns of the elderly are:

- Health
- Disability
- Dependency on others before dying
- Cost
- Quality of life

Elderly people often ask questions such as:

- Who will care for them before death?
- Will I be able to keep my dignity?
- Will I lose the respect of my family?
- What will happen to my personal belongings?
- Concerns regarding will, trusts, bonds, stocks, savings and checking accounts.

The chaplain will need to be prepared for questions and concerns such as these and become extremely knowledgeable in these areas. If the elder, dying, cannot get the answers they are seeking from family, friends or medical personnel, they will look to the Chaplain for answers and/or help.

CONVERSATIONS ABOUT DEATH

The chaplain will face death in many different settings and ways. While working in a nursing care facility one realizes that not all people there are elderly who die from old age. People of all ages live in these facilities and some have terminal illnesses and questions from the resident, family and friends arise.

There is never a “good time” or a “good way” to talk to someone who is dying about death or the process of death. Most people are afraid of it, even though they know that eventually, death is imminent sooner or later. Below are some suggestions regarding death:

TERMINAL ILLNESS

Many illnesses and diseases can be cured or controlled. Others have no cure. Many injuries can be repaired. Others are so serious that the body cannot continue to function. Recovery is not expected. The disease or injury will result in death.

An illness or injury for which there is no reasonable expectation of recovery is a terminal illness.

Doctors cannot tell exactly when a terminal illness will result in death. A person can be given days, month, weeks, or years to live. Predictions can be wrong.

Modern medicine has brought cures or has prolonged life in many cases. Future research is likely to bring new cures. Two very powerful psychological forces, however, influence living and dying. They are hope and the will to live.

When a chaplain helps those who are suffering from a terminal illness, there are a lot of questions, fears, doubts and emotions that run rampant. The chaplain must be willing to participate in the process of dying. Some suggestions that may help with this process are:

Don't be afraid to talk about the “end”: Many individuals find it easier to face if they are allowed to take part in planning process.

Listen to their wants and wishes: if they know that their wishes are going to be carried out and they will get what they want, facing “the end” becomes a completed process.

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Talk openly about the dying process: With a chronic illness, don't be afraid to talk about processes associated with treatment, time limits, saying good bye etc.

Talk about the "letting go process: Letting go is always hard for the individual who is dying and family and friends. Talk about the things that might give the individual or family more comfort such as:

- Visits
- Phone calls
- Letters and cards
- Saying, things that have been unsaid
- Asking for forgiveness, Saying thanks or I love you

ATTITUDES ABOUT DEATH

Life's experiences, culture, religion, and age influence a person's attitude about death. Many people fear death. Others refuse to believe they will die. Some look forward to and accept death.

Attitudes and beliefs about death often change, as a person grows older. They also are affected by changing circumstances.

Some people believe that life after death is free of suffering and hardship. They believe there will be a reunion with family and loved ones. Some believe there is punishment and suffering for sins and misdeeds in the afterlife. Others do not believe in an afterlife. They believe that death is the end of life. Depending on the personal belief and faith system of a person molds how they will look at death.

There also are religious beliefs about the form of the body after death. Some believe the body keeps its physical form. Others believe that only the spirit or soul is present in the afterlife. Still others believe in reincarnation.

Reincarnation is the belief that the spirit or soul is reborn into another human body or into another form of life.

Ideas about death change, as people grow older.

Infants and toddlers have no concept of death.

Children between the ages of 3 and 5 years start to be curious and have ideas about Death. They recognize deaths of family members or pets and notice dead birds or bugs. They view death as temporary. Children often blame themselves when someone or something dies. They see the event as punishment for being bad. When children ask questions about death, answers from adults often cause fear or confusion. Children who are told "He is sleeping" may be afraid to go to sleep.

Between the ages of 5 and 7 years, children view death as final. They do not see death in relation to themselves. Death is something that happens to other people. They also think death can be avoided. Children associate death with punishment and mutilation of the body. It also is associated with witches, ghosts, goblins, and monsters.

Adults have more fears about death than do children. They fear pain and suffering, dying alone, and invasion of privacy. They also fear loneliness and being separated from family and loved ones. They worry about who will care for and support loved ones left behind. Adults often resent death.

Elderly persons usually have fewer fears about death. They are more accepting that death will occur. They have had more experiences with dying and death. Many have lost family members and friends. Some welcome death as freedom from pain, suffering, and disability. However, elderly persons often fear dying alone.

THE STAGES OF DYING

The five stages of death have been identified as denial, anger, bargaining, depression, and acceptance.

DENIAL and ISOLATION

Upon receiving the information that one will not be able to live much longer, one responds by thinking that it can't be true. The response comes from simple rationality. Such news often seems like a hasty conclusion, and like any time when a rash statement is made, one says "Now hang on a minute. Let's see if there's really any cause for alarm."

Even though it's clear that there is no mistake, one still continues to make an effort to make sure it isn't something like a mistake. It is not uncommon for a person to check with numerous Doctors to make sure it's true. In such instances denial can cause extreme reactions.

Denial also comes at varying times throughout a dying patient's days, usually in milder, more subtle form. Sometimes one changes the subject when it's brought up, wanting to talk about something more cheerful and less negative.

Isolation is very much linked to denial. By having less interaction with others, one escapes the possibility of talking about the subject. It's very rare, however, for denial and isolation to be severe. There are very few instances where one makes a consistent, false reality all the way until the moment of death.

While both of these things sound like the "wrong way" to deal with death, they're an essential and natural way to relieve what can turn into constant negative emotion. The thought of one's own life ending soon is a thought that's very difficult to get out of one's mind.

It's nearly impossible to see death, accept it, and look past it into the remaining time one has.

So one must sometimes move the thought way, brush it aside, in order to look past it and live the remaining life.

ANGER

"Why me?" is a question which is the product of resentment, rage, envy and anger. And like anger that arises in every day situation, it can be transferred to people and situations that aren't related to what one is really angry at and which don't deserve such hostility.

A person may be in a bad mood in general. Often what triggers anger is envy, observing something that one can no longer do because of new physical limitations, or something cherished that one will not be able to experience after one's life is over. From such things, one can also have resentment towards God, for making their life end.

Also, the wish to convey that one is in fact still alive causes angry outbursts. Yelling and arguing are great ways to get attention, and sometimes one really wants others to be reminded that, while death is now a common topic of discussion, one isn't dead right now, not yet. Anger can be an assertion of life.

BARGAINING

A dying person will try to bargain with the higher power in which they believe. This reaction comes from life experience. One can often make a deal in order to get what is wanted.

This is a consistent strategy that's almost always worth trying during life, and when faced with something as strikingly negative as death, it's only natural to use that strategy which has succeeded so many times before.

Everyone wants to postpone their death as much as possible and promises might be made so that maybe they can live a little longer. Often this occurs in wanting to do a particular thing one last time.

Bargaining also very often continues, having more promises to do good things in return for various experiences. This points to the idea that wanting particular things "one last time" is merely a reflection of the broader, deep desire to have one's time to live extended.

DEPRESSION

This stage seems the most easy to understand after all, who wouldn't be extremely sad when he is about to die? But depression for a dying person isn't as clear as it seems. There are two different kinds, with two different causes.

The first depression's source is found in frustration and complication. Having to think about finances, family's emotions, medications, examinations, and a world of other issues is overwhelming.

Self-esteem is added into the mix when it's called into question by deteriorating physicality. All this adds to the second stage of anger, but also often causes a melancholy sadness. The second depression that a dying person goes into is about grief.

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There's much emotional turmoil in truly contemplating one's own death, and more significantly, the end of one's own life and all that is and used to be in it. Just as when one cries and is filled with sorrow at a loved one's end, so does one who is dying themselves. And in the same manner, it acts as emotional cleansing, necessary to the path of eventual acceptance.

ACCEPTANCE

A dying person, after enough time with the various stages in various orders, and even with various repetitions, comes to terms with their impending death. This is different than the acceptance of reality that occurs on the conscious, mental level of reason that usually happens well before the final stage of acceptance.

It isn't the same as giving up, either, nor is it a time of joy. This is the acceptance of quiet expectation, when one is neither happy nor sad, but serene.

Someone doesn't usually want to talk much or have things to do. However, a good thing to have in this final stage is company. Someone who can sit silently by a bedside, maybe holding a hand, is the best person to be with a person in the calm of acceptance.

Not everyone goes through these stages the same way or in the same order and some never reach the acceptance stage at all. Not only must the patient or the elderly person recognize what may happen, but so do family and friends. One of the responsibilities of the chaplain is preparing, not only the individual but family and friends for the death.

PSYCHOLOGICAL, SOCIAL, AND SPIRITUAL NEEDS

Dying persons have psychological, social, and spiritual needs. They may want family and friends present. They may want to talk about the fears, worries, and anxieties of dying. Some want to be alone.

There are two very important aspects of communication in dealing with the dying person. These are listening and touch. The person needs to talk, express feelings, and share worries and concerns. Let the person express feelings and emotions in his/her own way.

Just being there and listening helps the person's psychological needs. Don't worry about saying the wrong thing. Do not worry about finding the right words to comfort the person. Nothing really must be said. Do not feel that you need to talk. Silence, along with touch, is a very powerful and meaningful way to communicate.

Spiritual needs are important. The person may wish to see a priest, rabbi, minister, Chaplain or other clergy member. The person may also want to take part in religious practices.

Privacy is provided during spiritual moments. The resident/patient has the right to have religious objects nearby (medals, pictures, statues, or Bibles).

PHYSICAL NEEDS

Dying for each individual is different and the process may take a few minutes, hours, days, or weeks. There is a general slowing of body processes, weakness, and changes in the level of consciousness.

The individual may totally depend on others for basic needs and activities of daily living. Every effort should be made to promote physical and psychological comfort. Regardless of what length of time it takes. Always make sure the person is allowed to die in peace and dignity.

THE MEANING AND VALUE OF DEATH

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Each Nursing care facility chaplain should have an understanding of death and how others perceive it. Regardless of age, or type of death someone may have, the world has a view of the process.

Residents, family, friends and nursing staff have a belief of what they think death is and what it means. Each death process is different for every individual and extremely personal. This is an over view of how death is perceived.

Phenomenologically, death is nonbeing. The essential nature of life entails activity, purpose, and making order from disorder. Death is the direct opposite of life. Nonlife is inactive, and despite its stillness, death is chaos. Life generates its own meaning.

In contrast, death appears devoid of meaning and value. Because philosophically we cannot know anything with certainty about death, we must accept that death itself may (or may not) be meaningless.

Nevertheless, it is apparent that the fact of death profoundly impacts our understanding and experience of meaning in life. Although it remains unknowable, death's relationship to life is essential and as profound as the relationship of darkness to light.

Death need not illuminate life, it is sufficient for death to provide the background against which the light of life is seen. It is from this perspective, both clinically and philosophically, that the question: "What is the meaning and value of death?" becomes relevant and approachable.

Inquiry into the meaning and value of death can be approached from cultural, individual, and communal perspectives.

DEATH AND THE MEANING OF INDIVIDUAL LIFE

If death represents ultimate ego annihilation, it is no wonder that people have a dislike for thinking and talking about death. Thanatologist Herman Feifel quotes seventeenth century French writer and moralist, La Rochefoucauld, "One can no more look steadily at death than at the sun."

Contemplating nonbeing is a Gordian knot and attempting to understand death is inherently frustrating and can provoke considerable anxiety. Indeed a number of psychologists, including Freud, have considered death to be the root source of all human anxiety. It is interesting, however, that it is equally frustrating, although less anxiety provoking to contemplate on existence before one's conception and birth than after one's death.

It may not be the absence of one's being that causes emotional pain, but the loss of having been. The anguish of anticipated loss of relationships to others and the world is not evoked by contemplating people and the world before birth.

The human capacity to conceptualize time and, therefore, to conceptualize the future underlies the meaning of death. We can only speculate on other species' understanding and orientation toward death. Ethological observations reveal that animals flee from perceived threats to life instinctively, although these instincts can be overridden in special circumstances dare we say, for "a higher purpose"?

Although lower animals may not be able to conceptualize the meaning of death, it seems humans have no choice but to try. Anthropologists have long posited that humans are inherently "meaning makers."

Biologic evidence for an innate drive to make meaning include split-brain experiments with people born without connections between the two cerebral hemispheres or who have had the corpus callosum of their brains severed to control epilepsy.

Presented with disparate images shown to the right and left halves of their visual cortices, such individuals reflexively strive to interpret and explain the unrelated images as a meaningful whole. Particularly when a problem cannot be overcome, it is a trait of human nature, individually and culturally, to assign it a meaning. Faced with the ultimate problem and unalterable fact that life ends, human beings impulsively strive to recognize some meaning in death.

Awareness of death confronts us with questions that go to the very nature of existence. What is the nature of life? Is there continued existence beyond life? Does life have meaning? What is the meaning of my own life? These questions, asked in an infinite variety of ways, are part of the human confrontation with death.

Such questions define our place in the world and our relationship to others. They hold profound relevance to human life individuals and collectively, as families, community, and societies. A society's and culture's orientation toward the meaning of life and death underpin moral values and ethical norms of behavior.

Although inquiry of this nature is familiar to philosophers and theologians, most people actively avoid the subject of death. However, even for the least introspective among us, the ever present fact of mortality constantly threatens to wake us from the dream of life.

When sudden death, serious injury, or terminal illness strikes our family or circle of friends, the foundation of our world is shaken. From the moment an individual is diagnosed with an incurable illness, death becomes the alarm that will not stop ringing.

Even during remissions or times of relative health, its distant ring can be heard. The intrusion of death forces us to look at the things we want most to avoid. Philosophical issues that seemed abstract and avoidable acquire concrete relevance and immediacy.

Existential concepts such as the “aloneness” of each individual in the universe become all too real when faced with the approaching and inevitable loss of everyone we know and love. The person living with progressive illness directly experiences the profound implications that issues of meaning and value of life hold for the way we live, individually and collectively.

CULTURE AND THE MEANING AND VALUE OF DEATH

Our cultural and individual orientations toward death are intimately interwoven. We are at once a product of our culture and a participant in its ongoing evolution. It is well recognized that denial, or perhaps more accurately, suppression are psychological defense mechanisms that mark the orientation of Western culture toward death.

The culture tends to avoid serious consideration of death and avoidance behavior is readily documented. Even when confronted with unsettling news of the death of someone they have known, Westerners typically avoid questions that search for some meaning in death. Instead, in a manner that deflects deeper inquiry, typically people seek to ascribe a reason for the specific death.

We hear people ask, “Was he a smoker?” or, “Was she wearing her seat belt?” as if in assigning an explanation for an individual’s demise, one’s distance from death can be preserved. On the surface, the numerous examples of violent deaths in contemporary films, computer games, and other types of pop culture might seem inconsistent with this cultural trait.

However, such fascination with violence and gory death more likely represents an array of defense mechanisms such as reaction-formation or desensitization than any sort of mature effort to incorporate death within our individual psychological or collective cultural makeup.

If avoidance of death is so deeply rooted in our individual psyches and culture, it may be presumed that a world without death would represent a Utopia. Kastenbaum conducted a simple, but intriguing experiment that suggests otherwise.

In a two-phase written survey, 214 university students enrolled in a course on death-related topics were asked to express their feelings about living in a world without aging and death concisely.

The assignment was given prior to any readings or course work. Initial responses were 88% clearly positive. Typical written comments were, “You bet! Does it start now?” and “I love

it! This makes my day!” Students were then given a written homework assignment with specific instructions to consider and list (1) “the effects a world without death would have on other people and society in general,” and (2) “the effects a world without death would have on the way you live and experience your own life.”

The initial survey question was then repeated. The result was a dramatic reversal of frequencies with 82% giving negative responses and 18% positive. Expressed concerns about the absence of death on society clustered around issues of overcrowding, mandatory birth control, loss of rules governing human relationships, the conservative influence of massive numbers of elderly, the potential for economic systems to falter (“Kids wouldn’t get their inheritances”) and the erosion of religious beliefs.

Worrisome impacts on individuals’ lives included, loss of ambition, loss of meaning, loss of heaven, and less need to be responsible. Under the category, “loss of meaning,” Kastenbaum reports the following quotes as characteristic: “I just cannot think of myself going on and on, and things not coming to an end.

I’d have to ask myself what life is all about, and I don’t know that I can answer that question.” “I have a real hard time imagining what it would be like to live in this kind of life. To be honest, I don’t know what life would mean to me if I knew it was just going to go on and on” Of course, the implications of this thought experiment is limited.

Two hundred fourteen university students who elect to take a course on death and dying do not constitute a representative sample of the human population. Still, the consistency and dramatic reversal of responses warrants consideration.

Perhaps, as theologians, philosophers and poets have long suggested, life without death would be so monotonous and devoid of intensity, pathos and joy as to render the human condition meaningless. Indeed, it is not necessary to say that death gives life meaning to note that death may be necessary for life to have meaning.

HUMAN DEVELOPMENT THROUGH CONFRONTATION WITH DEATH

Rich empiric evidence from the biographic and medical literature has established that an individual’s confrontation with death can serve as a stimulus for personal growth.

In an essay written about a year after his diagnosis of esophageal cancer Dr. Bill Bartholome eloquently described his own personal adjustment to living with the knowledge of death’s approach.

It’s been little over a year now since I discovered I have a fatal disease. In trying to explain to family and friends what having this period of time has meant to me, I have found it helpful to characterize it as a gift. It has allowed me time to prepare my family for a future in which I will not be physically present to them.

It has given me the opportunity of tying up all the loose ends that our lives all have. I have been provided the opportunity of reconnecting with those who have taught me, who have shared their lives with me, who have touched my life.

I have been able to reconnect with those from whom I had become estranged over the years, to apologize for past wrongs, to seek forgiveness for past failings. But even more than all these, this gift has provided me the opportunity of discovering what it is like to live in the light of death, to live with death sitting on my shoulder. It has had a powerful effect on me, my perspective on the world and my priorities.

I like the person I am becoming more than I have ever liked myself before. There is a kind of spontaneity and joyfulness in my life that I had rarely known before. I am free of the tyranny of all the things that need to get done.

I realize more than I have ever before that I exist in a web of relationships that support and nourish me, that clinging to each other here against the dark beyond is what makes us human I have come to know more about what it means to receive and give love unconditionally.

To live in the bright light of death is to live a life in which colors and sounds and smells are all more intense, in which smiles and laughs are irresistibly infectious, in which touches and hugs are warm and tender almost beyond belief. I wish that the final chapter in all your stories can have a chapter in which you are given the gift of some time to live with your fatal illness.

THE MEANING AND VALUE OF DEATH

What is the nature of existence? Who am I? Who or what or where was I before I was born? Will “I” exist after death? Forced to live with knowledge of impending death, such questions assume poignant relevance. Some people experience severe spiritual or existential distress while others develop a seemingly paradoxical sense of “rightness” that characteristically involves realms of inner life.

A number of clinically reported accounts of positive subjective experience with life’s end document a transition through a sense of spiritual or existential distress to a sense of “wellness” despite full acknowledgment that death is near.

Recognition of these poles of human experience engendered by death’s approach from severe distress on the one hand to a profound sense of wellness on the other and the demonstrated potential for some individuals to move through suffering, make it imperative for clinicians who care for dying people to understand something about spiritual, existential and religious experience as they relate to life’s end.

The inherent mystery of existence is at once awe-inspiring and terrifying. In responding to that mystery people seek to discover some meaning within their own lives and within life in general and strive for a sense of connection to something larger than oneself that will endure into the open-ended future.

Listening for one or more of these themes has been helpful in understanding people's expression of profound distress on the one hand and seemingly paradoxical sense of personal well-being on the other.

In clinical evaluation and end-of-life research, I rely on a working definition for spirituality comprised of three themes: response to mystery, connection to something larger than oneself which endures into an open-ended future, and an experienced source of meaning.

Religion and spirituality are distant constructs. In the context of the present inquiry, religion may be considered a subset of spirituality. Religion refers to a coherent set of beliefs, values, schatology, knowledge, techniques, rituals, customs, and practices toward fostering a sense of connection and meaning and a way of dealing with the mystery of existence.

Religions often involve specific beliefs related to a deity or Supreme Being, but this is not a requirement. Religion is a principal way through which human beings have reached out to one another in community and across generations to provide guidance and support in confronting death. Not surprisingly, people who have a religious faith often find it provides a deep well of strength and source of comfort in dealing with illness, care-giving, death, and grief.

Existentialism arose in reaction to theistic religion. A contemporary dictionary defines existentialism as, "A philosophy that emphasizes the uniqueness and isolation of the individual experience in a hostile or indifferent universe, regards human existence as unexplainable, and stresses freedom of choice and responsibility for the consequences of one's acts."

It might well be presumed that existentialism and spirituality are opposites, mutually exclusive ways of approaching reality. In fact, an existential perspective may not obviate spirituality and even religion in the broadest sense.

Recent advances within physical and theoretical sciences, including chaos theory, suggest that within the haphazardness of reality there may be an underlying pervasive order. Even if there is no master plan, the intricacy of patterns and "laws" of mathematics, astrophysics, quantum mechanics, and molecular biology reveal a subtle, esthetic intelligence within the very fabric of physical reality.

Approached from the most coldly rational perspective, one cannot escape the implications of death on the meaning of life as individuals and, more particularly, life in relation to others.

Earth is but a speck of rock hurdling through space. The circumference of the earth is 24,901 miles at its widest point, fewer miles than many of us drive each year. All of us are but tiny creatures, living precariously on its surface, held by the mysterious happenstance of gravity, hurtling through deep space on this speck of rock, with only a thin blanket of air to warm and protect us from the frigid ravages of the Milky Way's galactic void.

Whether or not there is an active or watchful deity, human beings are still faced with the reality of living on this earth. The strictest, least sentimental existentialists, while decrying any notion

of meaning within the puny, insignificant human condition, is nevertheless faced with the predicament of living together, for whatever time we each have. An overarching question remains, "What are we going to do about it?"

THE DYING PROCESS

It is vital that the chaplain understand the dying process. More than likely the chaplain will be called during this process. The chaplain may be called on to explain to family and friends about what nurses and Dr's may be doing.

It is very important that the chaplain KNOW these processes due to the time frame of the imminent death. The chaplain will know what to expect when the body shuts down.

- Normally the individual's vision becomes blurred and gradually fails during the dying process. The person naturally turns toward light. A darkened room may be frightening. The eyes may be half open. Secretions may collect in the corners of the eyes.
- Because of failing vision, the chaplain may need to explain what is being done to the person or in the room to family and friends.
- You may need to explain specific procedures while in this process. You may need to explain that the eyes should be covered, or that speech becomes difficult and may be hard to understand.
- The chaplain should not ask questions that need long answers. "Yes" or "No" questions can be asked but should be kept to a minimum.
- Although speech may be difficult or impossible for the person, you must still talk to him or her and encourage the family to do the same. Let them know that there is nothing to be afraid of.
- Hearing is one of the last functions to be lost during the dying process. Many people hear until the moment of death. Even if unconscious, the person may hear.
- Always assume that the dying, or any unconscious person, can hear. Speak in a normal voice, and provide reassurance and explanations about care. Offer words of comfort and you can encourage the family to do the same.
- Topics that could upset the resident/patient or family should be avoided.

MOUTH, NOSE, AND SKIN

- Oral hygiene is very important for comfort.
- Routine mouth care usually is enough if the resident/patient can eat and drink. Frequent oral care is given as death nears and when the person has difficulty taking oral fluids. Oral hygiene also is important if mucus collects in the mouth and the person cannot swallow.
- Crusting and irritation of the nostrils can occur.
- Common causes are increased nasal secretions, an oxygen cannula, or an NG tube. The nurses may have you apply a lubricant to the nostrils.
- Circulation fails and body temperature rises as death approaches. The skin is cool and pale. Perspiration increases.

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- Linens and gowns may be changed whenever needed because of perspiration. Although the skin feels cool, only light bed coverings may be needed. Blankets may make the person feel warm and cause restlessness.

ELIMINATION

- Dying persons may have urinary and anal incontinence.
- Some residents/patients have constipation and urinary retention.

COMFORT AND POSITIONING

- Measures are taken to promote comfort. Good skin care, personal hygiene, back massages, and oral hygiene help to increase comfort.
- Some people have severe pain. They may be given strong pain medications by nurses or Dr's.
- You can promote comfort by frequent position changes. Good alignment and supportive devices also promote comfort.

THE FAMILY

- The family is going through a hard time. It may be very hard to find words to comfort them. You can show your feelings to the family by being available, courteous, and considerate. Use touch to show your concerns.
- The family is usually allowed to spend time with their loved one. The chaplain must always respect the family and patient's right to privacy. They need as much time together as possible.
- The family may be very tired, sad, and tearful. They need support and understanding. Watching a loved one die is very painful. So is dealing with the eventual loss of that person.
- In their grief the family goes through stages like the dying person. They may be very angry. Do not take this anger personally.
- Try to understand. Treat the family with courtesy and respect. Visiting with a member of the clergy may be comforting to the family.
- You need to communicate this request to the nurse immediately.

DO NOT RESUSCITATE ORDERS

Some family members do not know about DNR's, neither their meaning nor their importance and may not know that the individual has one on file. There may be issues with the family over a DNR. The chaplain must have knowledge about a DNR for the sake of speaking with the family when questions arise.

- When death is sudden and unexpected, every effort is made to save the person's life.
- CPR is started. Nurses, doctors, and other emergency staff members rush to the person's bedside. They bring emergency and life-saving equipment. CPR and other life support

measures are continued until the person is resuscitated or until declared dead by the doctor.

- Doctors often write do not resuscitate (DNR) orders for terminally ill residents/patients. This means that no attempts will be made to resuscitate the person. The person will be allowed to die with peace and dignity.
- The orders may or may not be written after consulting with the resident's/patient's family. When the family is aware of the DNR the family makes the decision if the resident/patient is not mentally able.

LIVING WILLS

Some persons, especially terminally ill or elderly, choose not to be resuscitated. They have the right to refuse treatment. Some have written instructions about acceptable treatments and life-prolonging measures. These are called "living wills."

A living will states that the person does not want life prolonged by extraordinary means if there is no reasonable expectation of recovery.

As of 1994, 41 states allow living wills. State laws vary. Most require that the person making the will be 18 years of age or older. Some states require new living wills every 5 or 7 years.

Living wills have been a focus of financial abuse of elderly persons. Some have been charged excessive legal fees, as much as \$8,000. Be aware that living wills can be drawn up free or for a very small charge. A local Legal Aid office will give you assistance in making living wills.

The chaplain has no decision making power about any treatment or procedure and they must follow the resident's/patient's or family's wishes and the doctor's orders. These may be against your personal, religious, and cultural values. If so, discuss the situation with the nurse. It may be necessary to change your assignment.

SIGNS OF DEATH

The attending chaplains should know the signs of approaching death. The following signs may occur rapidly or gradually:

- Movement, muscle tone, and sensation are lost. This usually begins in the feet and legs and eventually spreads to the rest of the body. When mouth muscles relax, the jaw drops. The mouth may stay open. There is often a peaceful facial expression.
- Peristalsis and other gastrointestinal functions slow down. There may be abdominal distention, anal incontinence, fecal impaction, nausea, and vomiting.
- Circulation fails and body temperature rises. The person feels cool or cold, looks pale, and perspires heavily. The pulse is fast, weak, and irregular. Blood pressure begins to fall.
- The respiratory system fails. Slow or rapid and shallow respirations may be observed. Mucus collects in the respiratory tract. This causes the "death rattle" to be heard.

- Pain decreases as the person loses consciousness. Some persons, however, are conscious until the moment of death.
- The signs of death include the absence of pulse, respirations, and blood pressure. The pupils are fixed and dilated.
- A doctor determines that death has occurred and pronounces the person dead.

NOTES

CHAPTER 12 WHAT IS BEREAVEMENT AND WHAT IS GRIEF?

Bereavement is defined as a state of sadness or loneliness. Grief is the collection of feelings and behaviors associated with the loss of a person. The loss is commonly caused by death of a friend or family member. However, the loss can also be caused by such events as someone moving away or by a divorce

When someone is bereaved, they usually experience an intense feeling of sorrow called grief. People grieve in order to accept a deep loss and carry on with their life. Experts believe that if you don't grieve at the time of death, or shortly after, the grief may stay bottled up inside you.

This can lead to emotional problems and even physical illness later on. Working through your grief can be a painful process, but it's often necessary to ensure your future emotional and physical wellbeing.

What feelings and behaviors are associated with bereavement and grief?

Some feelings associated with bereavement and grief's are:

- Numbness
- Loneliness
- Sadness
- Guilt
- Shock
- Anxiety
- Depression
- Anger
- Agitation.

Some behaviors associated with bereavement and grief is:

- Crying
- Insomnia
- Restlessness
- Withdrawal

What are some of the characteristics associated with grief?

It is extremely common for the person who is grieving to be critical of himself/herself for either doing something to or not doing something for the person who has died or left.

It is also common for the grieving person to think that he/she should have died instead of the loved one. It is not unusual for the grieving person to be angry toward others, especially other family members or God.

During the grief process many people are surprised to feel the strongest feelings they have ever felt in their lives. Having a depressed mood during grief is quite normal.

- Insomnia
- Crying spells
- Social withdrawal

However, a sense of worthlessness, severe guilt, or thoughts of suicide can signal a problem with the grief process. An evaluation and treatment by a professional can often help the person deal with both normal and abnormal feelings of grief.

ANTICIPATORY GRIEF

Anticipatory grief is usually experienced by someone who is observing a loved one die slowly from a terminal illness or an unexpected injury. During this period some people prematurely separate and withdraw from their dying loved one, and therefore, anticipatory grief can sometimes lessen the impact of the loss at the time of death. At other times, however, the person feels a strong sense of closeness to the loved one during the anticipatory grief period, and this leads to a greater sense of loss at the time of death.

HOW IS GRIEF TREATED?

Although most people recover from their grief, there are those who get stuck in the grieving process. Frequently, brief supportive therapy can be helpful. Support groups can also be quite helpful because a group provides the grieving person with mutual support, empathy, and understanding.

Sometimes the grieving person may need medications for depression if the depression becomes severe or if it lasts for more than a couple of months. Also, medications are helpful to the person suffering from prolonged insomnia or excessive anxiety associated with grief.

WHAT HAPPENS TO SOMEONE WITH GRIEF?

There are usually three overlapping phases of grief:

- Shock and denial
- Anguish
- Resolution

First, a person experiences feelings of disbelief and numbness upon the loss of someone close. The person often describes "being in shock" or "in denial." This period might last just a few minutes, but it can also persist for weeks.

Next, a person in grief goes through a time of acute anguish. During this period he/she experiences waves of distress lasting from a few minutes to an hour or more. Emptiness,

weakness, and mental pain are common feelings. The person might believe that he/she can actually see, hear, or communicate with the deceased person.

During the third phase, which can last many months, resolution of the loss takes place, and the grieving person returns to his/her usual activities.

People in grief often experience the same symptoms as those associated with depression. Depressive symptoms such as poor appetite, insomnia, and weight loss are frequently present.

While some people experience unusually intense and disruptive feelings of grief, still others do not express the feelings that are expected or that are considered usual, normal, or healthy during the grieving period. Rather, these people encounter a muted, delayed, or inhibited reaction to the loss of their loved one.

Although most people normally recover from their grief, some people do not, and they experience an intense, prolonged, or chronic grief. If the grief period is too intense, too long, or too inhibited an evaluation and treatment by a professional is recommended.

THE STAGES OF GRIEF

There is no single or correct way to grieve. Everyone is different and each person grieves in his or her own way. However, some stages of grief are commonly experienced by people when they are bereaved. There is no set timescale for reaching these stages, but it can help to know what the stages are and that intense emotions and swift changes in mood are normal.

The stages of grief aren't distinct, and there is usually some overlap between them.

Feeling emotionally numb: This may last for a few hours, days or longer. In some ways, this numbness can help you get through the practical arrangements and family pressures that surround the funeral, but if this phase goes on for too long it can become a problem.

Numbness may be replaced by a deep yearning for the person who has died. For example, every time the phone rings you might expect it to be the person who has died, or you may think you see him or her on the bus or in crowds.

You may feel agitated or angry: and find it difficult to concentrate, relax or sleep. You may also feel guilty, dwelling on arguments you had with that person or on emotions and words you wished you had expressed.

This period of strong emotion usually gives way to bouts of intense sadness, silence and withdrawal from family and friends. During this time, you may be prone to sudden outbursts of tears, set off by reminders and memories of the dead person.

Over time, the pain, sadness and depression start to lessen. You begin to see your life in a more positive light again. Although it's important to acknowledge there may always be a feeling of loss, you learn to live with it.

The final phase, letting go: letting go of the person who has died and carry on with your life, though it may not be exactly the same as it was before. Your sleeping patterns and energy levels return to normal.

HOW LONG DOES GRIEVING TAKE?

The grieving process can take some time. How long it takes depends on you and your situation. In general, though, it usually takes one to two years to recover from a major bereavement.

COPING WITH THE GRIEVING PROCESS

There are many things you can do to help someone cope during the grieving process.

- Ask for help and support from family, friends or a support groups.
- Try to get them to express whatever they are feeling, be it anger, guilt or sadness.
- Help them in accept that some things, like death, are beyond your control.
- Help them avoid making major decisions as their judgment may be affected and changes could increase their stress levels. Suggest children or other family members help in that area.
- Counsel the person on giving themselves time, space and permission to grieve. By doing so, they are able to mourn properly and avoid problems in the future.

WHAT IF THEY AREN'T COPING?

Sometimes, the grieving process is especially difficult. Some find it impossible to acknowledge the bereavement at all, which can mean that their feelings aren't worked through properly. It may also happen if you don't have time to grieve properly, perhaps because of work pressures or if you are looking after your family.

Others may be unable to move on from their grief, or remain in the numb stages of grief, finding it hard to believe the person is dead for years.

Such difficult grieving can lead to recurring bouts of depression, loss of appetite and even suicidal feelings. According to Mind (the National Association for Mental Health), you are more likely to have a difficult grieving process if:

- The person is alone and have no support from your community, family, or friends
- If there was unresolved issues with the person who died
- The death was caused by a particularly difficult event such as a national disaster or an unsolved murder
- The person goes missing or it isn't clear exactly what happened
- The person is unable to attend the funeral or there isn't one

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Other circumstances around the death can lead to a difficult grieving process. These include:

- A sudden or unexpected death
- The death of a parent when you are a child or adolescent
- Miscarriage or the death of a baby death
- Suicide of a resident

When clergy, chaplains, and pastoral counselors are attempting to be caregivers of the institutionalized elderly, there are things that you should consider trying to help residents focus on grief, loss, and bereavement. They include:

- Focusing on the emotional responses and phases of dying, including denial, anger, and acceptance, to help patients deal with death.
- Consider the physical and administrative atmosphere and your elderly population when setting goals and designing programs to provide optimal patient/resident care
- Discuss the themes of grief and loss, stress management, handling change, and promoting self-care for caregivers.
- Develop a program having themes based on the biological, psychosocial, and spiritual needs of the elderly person and help them face their own mortality.

The loss of a life is life's most stressful event and can cause a major emotional crisis. After the death of someone you love, you experience bereavement, which literally means "to be deprived by death."

SYMPTOMS OF GRIEF AND LOSS

- Denial
- Yearning
- Disbelief
- Anger
- Confusion
- Humiliation
- Shock
- Despair
- Sadness
- Guilt

These feelings are normal and are common reactions to loss. You may not be prepared for the intensity and duration of your emotions or how swiftly your moods may change. You may even begin to doubt the stability of your mental health.

It is important to be reassured that these feelings are healthy and appropriate. These feelings and expressions of powerful emotions help you come to terms with your loss.

Remember, it takes time to fully absorb the impact of a major loss. You never stop missing a friend or loved one, but the pain eases after time and this allows you to go on with your life.

MOURNING A LOVED ONE

It is not easy to cope after a loved one dies. You will mourn and grieve. Mourning is the natural process you go through to accept a major loss. Mourning may include religious traditions honoring the dead or gathering with friends and family to share your loss.

Mourning is personal and may last months or years. Grieving is the outward expression of your loss. Grief is likely to be expressed both physically and psychologically. For instance, crying is a physical expression, while depression is a psychological expression.

It is very important to allow yourself to express your feelings. Often, death is a subject that is avoided, ignored or denied. At first it may seem helpful to separate yourself from the pain or ignore your feelings, but you cannot avoid grieving forever. Someday those buried feelings will need to be resolved or they may cause physical or emotional illness.

Many people report physical symptoms that accompany grief. Stomach pain, loss of appetite, intestinal upsets, sleep disturbances and loss of energy are all common symptoms of acute grief. Of all life's stresses, mourning can seriously test your natural defense systems. Existing illnesses may worsen or new conditions may develop.

Profound emotional reactions may occur. These reactions include anxiety attacks, chronic fatigue, depression and thoughts of suicide. An obsession with the deceased is also a common reaction to death.

A spouse's death is very traumatic. In addition to the severe emotional shock, the death may cause a potential financial crisis if the spouse was the family's main income source. The death may necessitate major social adjustments requiring the surviving spouse to parent alone, adjust to single life and maybe even return to work.

Elderly people may be especially vulnerable when they lose a spouse because it means losing a lifetime of shared experiences. At this time, feelings of loneliness may be compounded by the death of close friends.

A loss due to suicide or tragedy can be one of the most difficult losses to bear. It may leave the survivors with a tremendous burden of guilt, anger and shame. They may even feel responsible for the death. Often, survivors benefit from professional advice to cope with this devastating experience. Seeking counseling as a family unit during the first weeks after the death is particularly beneficial and advisable.

LIVING WITH GRIEF

Coping with death is vital to your mental health. It is only natural to experience grief when a loved one dies. The best thing you can do is allow yourself to grieve. There are many ways to cope effectively with your pain.

Seek out caring people. Find relatives and friends who can understand your feelings of loss. Join support groups with others who are experiencing similar losses.

Express your feelings. Tell others how you are feeling; it will help you to work through the grieving process.

Take care of your health. Maintain regular contact with your family physician and be sure to eat well and get plenty of rest. You should not sleep more than 10 hours a day without your doctor's approval. Be aware of the danger of developing a dependence on medication or alcohol to deal with your grief.

Accept that life is for the living. It takes effort to begin to live again in the present and not dwell on the past.

Postpone major life changes. Try to hold off on making any major changes, such as moving, remarrying, changing jobs or having another child. You should give yourself time to adjust to your loss.

Be patient. It can take months or even years to absorb a major loss and accept your changed life.

Seek outside help when necessary. If your grief seems like it is too much to bear, seek professional assistance to help come to terms with your loss and work through your grief. It's a sign of strength, not weakness, to seek help.

WHEN OTHERS GRIEVE

When helping someone you care about during a loss of a loved one, you can help them through the grieving process:

Share the sorrow. Allow them, even encourage, them to talk about their feelings of loss and share memories of the deceased. Listen. Don't pressure.

Don't offer false comfort. It doesn't help the grieving person when you say "it was for the best" or "you'll get over it in time." Instead, offer a simple expression of sorrow and take time to listen.

Offer practical help. Running errands or just helping out are all ways to help someone who is grieving. Just having someone around who is generous but not intrusive can help.

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Be patient. Remember that it can take a long time to recover from a major loss. Make yourself available to talk.

Encourage professional help when necessary. Don't hesitate to recommend professional help when you feel someone is experiencing too much pain to cope alone. You might make a list of professionals who specialize in grief, trauma or major life transitions.

HELPING FAMILY OR FRIENDS

If a resident or someone you know has been bereaved, the best thing you can do is spend time with them and listen to them work through their grief. Offer practical help, such as cooking dinner or shopping for food, when a person is grieving, it's usually hard to focus on everyday tasks.

You might feel awkward because you don't know what to say to the bereaved, but just being there will be a great help and lets them know that you care and haven't forgotten. Just remember, sometimes it's better to just say nothing.

NOTES

CHAPTER 13 WHEN THE ELDERLY ARE VICTIMIZED

When elderly people are victimized, they usually suffer greater physical, mental, and financial injuries than other age groups. Elderly victims are twice as likely to suffer serious physical injury and to require hospitalization as any other age group.

The physiological process of aging brings a decreasing ability to heal after injury both physically and mentally. Elderly victims may never fully recover from the trauma of their victimization. Also, the trauma that elderly victims suffer is worsened by their financial difficulties. Because many elderly people live on a low or fixed income, they often cannot afford the professional services and products that could help them in the aftermath of a crime.

It is understandable why the elderly are the most fearful of crime. Elderly people, in fact, face a number of additional worries and fears when victimized.

They may doubt their ability to meet the expectations of law enforcement and worry that officers will think they are incompetent. They may worry that a family member, upon learning of their victimization, will also think they are incompetent. They may fear retaliation by the offender for reporting the crime.

Elderly people may experience feelings of guilt for “allowing” themselves to be victimized. Depending on your approach as a first responder, you can do much to restore confidence in and maintain the dignity of the elderly victims you work with.

TIPS FOR RESPONDING TO ELDERLY VICTIMS

- Be attentive to whether victims are tired or not feeling well.
- Allow victims to collect their thoughts before questioning.
- Ask victims if they are having any difficulty understanding you. Be sensitive to the possibility that they may have difficulty hearing or seeing, but do not assume such impairments. Ask victims if they have any special needs, such as eyeglasses or hearing aids.
- Ask victims whether they would like you to contact a family member or friend.
- Be alert for signs of domestic violence or neglect, since studies indicate that 10 percent of the elderly are abused by their relatives.
- Give victims time to hear and understand your words during the interview.
- Ask questions one at a time, waiting for a response before proceeding to the next question. Avoid interrupting victims.

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- Repeat key words and phrases. Ask open-ended questions to ensure you are being understood.
- Avoid unnecessary pressure. Be patient. Give victims frequent breaks during your interview.
- Protect the dignity of victims by including them in all decision making conversations taking place in their presence.
- For hearing-impaired victims, choose a location free of distractions, interference, and background noise, and:
 - Face the victim so your eyes and mouth are clearly visible.
 - Stand or sit at a distance of no more than 6 feet and no fewer than 3 feet from the victim.
 - Begin speaking only after you have the victim's attention and have established eye contact.
 - Never speak directly into the victim's ear.
 - Speak clearly, distinctly, and slightly slower than usual. Keep your questions and instructions short and simple. Do not over articulate your words.
 - If necessary, talk slightly louder than usual but do not shout. Extremely loud tones are not transmitted as well as normal tones by hearing aids.
 - Be prepared to repeat your questions and instructions frequently. Use different words to restate your questions and instructions.
- Provide enhanced lighting if victims are required to read. Ensure that all print in written materials is both large enough and dark enough for victims to read.
- Provide victims written information that summarizes the important points you communicated verbally so they can refer to this information later.
- Remember that elderly victims' recollections may surface slowly. Do not pressure them to recollect events or details; rather, ask them to contact you if they remember anything later.

In all your comments and interactions with elderly victims, their families, and other professionals involved in the case, focus on the goals of restoring confidence to and maintaining the dignity of the elderly victims you work with.

ELDER ABUSE STATISTICS

The National Crime Victimization Survey reports that the rate of violent crime victimization of persons ages 65 or older was about 4 per 1,000 (Bureau of Justice Statistics, 2001).

Persons ages 65 or older numbered 34.5 million in 1999, about 13% of the U.S. population (Administration on Aging, 2000).

The National Elder Abuse Incident Study reports that an estimated total of 551,011 elderly persons, aged 60 and over experienced abuse, neglect, and/or self-neglect in domestic settings in 1996 (National Center on Elder Abuse, 1998).

The most frequent forms of elder abuse reported to adult protective service agencies included neglect (48.7%), emotional/ psychological abuse (35.4%), financial/ material exploitation (30.2%), physical abuse (25.6%), and abandonment (3.5%).

Adult children are the largest perpetrators of elder abuse (47.3%), followed by spouses (19.3%), other relatives (8.8%), and grandchildren (8.6%).

According to the Family Violence Task Force, references to elder abuse can be traced throughout Greek mythology, the writings of Shakespeare and modern literature. Yet, it has only been in the last twenty years that serious attention has been given to family violence and elder abuse. Perhaps, at least in part, this elevated consciousness can be attributed to the increasing numbers of aging Americans.

Her testimony prompted the House Select Committee on Aging, chaired by the late U.S. Representative Claude Pepper, to further examine the mistreatment of the elderly. The "Pepper Committee" subsequently introduced the term "elder abuse," and alerted the nation to the widespread severity of this problem .

OVERVIEW

The effects of the baby boom and increased life expectancy have both contributed to the immediate and projected increase in the number of elderly Americans. Medical advances and the implementation of "protective legislation" have greatly increased the length of life for many Americans (Griffin and Williams, 1992).

Yet, other simultaneous societal changes may have contributed to the predisposition of some individuals to become abusive towards the elderly. In previous generations extended family members could share the responsibility of caring for the aging.

However, increased mobility, strained economic times and smaller nuclear families have limited familial resources. Currently, the responsibility of elder care usually falls on a select few (Griffin and Williams, 1992).

The definitions and statistics regarding elder abuse vary. They range from estimates that one out of ten persons living with a family member is subject to abuse approximately 2.5 million a year (Griffin and Williams, 1992)--to 1 in 25 elderly persons being victimized annually (Heisler, 1991).

Still others conclude that 3.6 percent of our Nation's elderly citizens are victims of abuse each year. Most researchers agree that the abuse of the elderly fall within the five following categories: physical abuse, sexual abuse, psychological abuse, financial abuse and neglect.

PHYSICAL ABUSE

"Non-accidental physical force that results in injury" Family Violence Task Force Report, 1988".

Indicators:

- Fractures and dislocations
- Lacerations and abrasions
- Burns
- Injuries to the head, scalp, face; and/or
- Bruises on upper arms (from shaking), around wrists or ankles (from being tied down), in shapes
- Similar to objects, inside of thighs or arms (Bloom,1989).

Physical frailty, decreased physical ability, and vision and audio impairments make older persons especially susceptible to physical abuse.

SEXUAL ABUSE

"Non-consensual sexual contact" (Family Violence Task Force Report, 1988).

Indicators:

- Sexually transmitted diseases; and/or
- Pain, itching, bleeding or bruising in the genital area.

As elderly victims are less physically able, often all that is needed to subdue them during a sexual assault is intimidation by physical force (Muram, Miller and Cutler, 1992).

PSYCHOLOGICAL ABUSE

"Infliction of mental anguish by threat, intimidation, humiliation, or other such conduct" (Family Violence Task Force Report, 1988).

Indicators:

Low self-esteem
Overly anxious or withdrawn
Extreme changes in mood

DEPRESSION

Suicidal behavior; and/or
Confusion or disorientation (Bloom, p. 41, 1989).

Diminished ability to cope with stress, termed a "decrease in homeostatic capacity," as well as the state of "chronic loss" that often accompanies aging (i.e., loss of one's home, peers, spouse, etc.), renders elders susceptible for psychological abuse).

Financial Abuse

"Unauthorized use of funds or property" (Pennsylvania Attorney General's Family Violence Task Force Report, 1988).

Financial abuse or exploitation involves the theft or conversion of money or property belonging to an elder, accomplished by force, misrepresentation, or other illegal means often by taking advantage of the elder's partial or total lack of legal competency (Hyman, p. 6, 1990).

The loss of what may appear to be a minimal amount of money to some may account for a substantial loss for an elder person. It may result in the elder having to go without food, medication, or possibly his or her apartment.

Neglect:

"Failure to fulfill a caretaking obligation" (Family Violence Task Force Report, 1988).

Indicators:

- Poor personal hygiene
- Signs of overmedication, under-medication, and/or misuse of medication
- Incontinent elder dressed in soiled clothing
- Elder left alone and deprived of stimulation and affection
- Malnutrition

The different types of neglect include the following:

Active Neglect: willful failure to provide care.

Passive Neglect: inadequate knowledge or infirmity of caretaker, resulting in non-willful failure to provide care.

Self-neglect: failure of elder to care for her or himself (Family Violence Task Force Report, 1988).

In addition to the abuse that elderly persons are subject to by relatives and/or caretakers in their homes or in institutions, they may also become targets for criminal victimization. Contrary to popular assumptions that elderly citizens are disproportionately victims of crime as a result of their physical limitations, in reality, they are the least victimized age group.

Yet, further examination does reveal that elderly persons may be subject to more severe crimes, and that they are more fearful of crime; thus the consequences of victimization are often more detrimental (Family Violence Task Force Report, 1988).

The low victimization rate for elderly persons may be explained by their lifestyles, which limit the amount of time they spend out in the evening and their contact with likely offenders. However, this does not safeguard them from becoming victims of serious crimes.

Research indicates that personal larceny with contact (pocket-picking, purse snatching), a significant and dangerous crime as it involves both theft and personal contact, is the most common crime against elderly Americans. Robbery, inclusive of both theft and assault, is second in frequency. In addition, the following are further aspects that characterize the severity of crimes against the elderly:

- Elders are twice as likely as younger persons to be victimized in or near their homes.
- Elders are more often victimized by offenders with weapons, including firearms.
- Elders are more likely than younger persons to be victims of violent crime perpetrated by strangers.
- Elders suffer greater physical, psychological, and financial loss when victimized.
- Elders are more easily injured, heal more slowly, are less resilient emotionally, and are less financially stable than younger victims (Family Violence Task Force Report, 1988).

NOTES

CHAPTER 14 ELDERLY HEALTH RELATED ISSUES

While working at a nursing home facility, the chaplain will encounter residents with various different illnesses or diseases. It is important that the chaplain know how to approach these residents. In this module, we will discuss the various types of illnesses or actions and how to best approach the person.

Chaplains are not trained in the medical field and should not attempt to do or say thing that may cause problems. Have staff members attend to medical issues. However, when trying to visit with a resident that suffers from different diseases such as Alzheimer's, these are some things that you might be able to help with.

ALZHEIMERS AND SENILE DEMENTIA (Carly Hellen, Rush Alzheimer's Disease Center)

VERBAL ANXIETY (FEELING LOST, SCARED, I DON'T KNOW WHAT TO DO)

- Approach slowly
- Redirect to object, activity, prop, conversation
- Use touch in a gentle, reassuring way
- Take residents to the most familiar setting on unit to sit in relaxed and feel more secure
- Reassure with familiar props, locations, activities, etc.
- Involve resident in positive peer relationships, perhaps with someone who needs to reassure or nurture someone else
- If asking what's wrong, use validation to listen for the reason underlying the anxiety, then try to resolve
- Involving normalization activities resident is capable of doing
- Allow residents to sit in area where staff are working to feel he or she isn't alone

REPETITIVE CALLING OUT; YELLING, SCREAMING

- Use slow, rhythmic music, lifelong favorite music.
- Use refreshments
- Give resident a busy box, scrap book, props to occupy attention and interest
- Spend one on one time in quiet and non-distracting area; use soft voice so that perhaps resident will have to stop yelling to hear you
- Use the resident's name and look directly at him or her in trying to calmly breakthrough
- Assess whether the resident is in pain, discomfort.
- Assess whether something or someone is causing the behavior
- Try to involve in singing instead

VERBAL ANGER; ABUSIVE LANGUAGE

- Distract and redirect
- Introduce singing instead

- Introduce a "favorite" of the resident; activity, music, food, person
- Involve in craft or physical activity where anger could be expressed in nonverbal manner
- Involve in social settings that clearly cue the use of manners or appropriate social skills
- Do not react with shock, scolding, anger, parental tone

EXPRESSION OR DISPLAY OF SADNESS; DEPRESSION

- Use validation techniques to find a reason behind the behavior, don't ask "why"?
- Involve in or use something from resident's lifetime that has offered enjoyment or comfort
- Do and say things that make the resident feel of value or special
- Involve in activities that you are certain residents can be successful in doing; give genuine praise
- Acknowledge and accept what the resident is expressing
- Use music: sad music may help you release feelings; happy may offer distraction
- Use something to offer comfort to, to cuddle, pat, tactile stimulation

SHORT ATTENTION SPAN; EASILY DISTRACTED

- Break the activity into short sections
- Use a lifelong, normalization, familiar activities
- Use of props, pictures, materials to assist in holding resident's attention
- "Roving" activities; take the activity to where the resident is on the unit, rather than time to keep the residents attention in an activity group or area
- Use of resident "jobs"/ roles in activity; making it important to stay involved
- Put out materials and allow or assist resident in going from "station to station"
- Manual activities; task oriented activities; tactile stimulating materials
- Seat in group or at a table or in an area in a way that the resident faces the fewest number of distractions
- Change activity, approach, tone of voice that you notice resident is losing interest
- As you notice increase in distractibility, ask resident a question or give one on one to regain interest
- Inter-generational activities

WANDERING, PACING

- Involve in physical or movement activities
- Set up things to stop look at and/or do long away
- Normalization activities: sorting jewelry or stocks; tying laces; untying or unknotting socks; sorting and folding laundry; sweeping; testing
- Use activities that can occur while walking
- Set up "comfort" areas (chair, pillows, couch, music playing, things to look at) that draw resident in to rest
- Dancing

ELOPING (PURPOSEFUL ACTIONS TO LEAVE AREA OR BUILDING)

- Walk with the resident using a non-directed conversation to distract or calm resident
- Setup planned walking activities
- Involve resident in tasks of the unit- making beds; sweeping, pushing cart with staff
- Disguise the unit's exits
- Assess times of day this happens; look for environmental cues -such a staff leaving to go home-and eliminate
- Involve in activity prior to this time of day
- Involve in activities that match the reason the resident has to leave-cooking, work, childcare

REPETITIVE PHYSICAL MOVEMENTS

- Activities that naturally involve repetitive movements-sanding, dusting, stuffing
- Rhythms band; dancing; movement to music; exercise
- Work oriented repetitive activities: sorting, stapling, stamping, cutting, folding

PHYSICAL COMBATIVENESS, AGGRESSION

- Remove resident from the situation to calm, quiet area without making a big deal about it
- Massage. Stroke or hold residents hand, if he or she will allow. Brushing hair
- Dancing, singing, rhythmic music, clapping, marching
- Physical activity with gross motor movements, and safe props, if any; walking; ball activities
- Repetitive manual activities like crumpling or tearing newspaper for stuffing
- Give the resident something safe-non breakable-to hold
- Find ways in which the resident could have some element of control in the situation
- Normalization or repetitive activities that can be done alone
- Give the resident some space; Decreased stimuli in the environment
- Use of smells or foods that are soothing or comforting

RUMMAGING; PILLAGING; HOARDING

- Therapeutic "purses", bags, etc. filled with belonging that the resident can keep
- Redirection
- Display items that can safely be picked up and taken by the resident; pegboard with collection of hats on, jewelry that belongs to the unit
- Don't simply take something away from the residents; "trade" it for acceptable item
- Check their hiding places,

SUNDOWNING

- Suggest family visits at this time, if possible
- Use normalization and helping types of activities
- Consider a psychosocial group to address through group techniques/ relaxation techniques

CATASTROPHIC REACTION

- Identify the stressor(s) can eliminate or reduce as much as possible
- Identify resident's "symptoms" leading up to reaction, and intervene at that time
- Use a consistent approach whenever dealing with catastrophic behavior
- Use enough-but not too many-staff to intervene in as calm a way as possible
- Determine successful ways to redirect residents and communicate these to all of the staff working with the patient

TRAUMA and the ELDERLY

Traumatic events can occur at any point or during any period of the life cycle: some individuals may undergo long periods of traumatic stress, such as that experienced in combat or in prisoner-of-war camps; others may experience only one incident, such as a rape, or the Oklahoma City bombing.

There is some evidence to suggest that early; repetitive trauma such as that experienced by children growing up in an abusive family may have permanent developmental effects, leaving the individual vulnerable throughout the life span.

Though reactions to traumatic events can vary widely among individuals, there is some evidence that as external and internal resources diminish in later life, prior trauma may renew its hold. Consequently, delayed onset, reemergence, or exacerbation of symptoms and behaviors associated with posttraumatic stress may appear during the aging process.

Indeed, aging may prove to be a risk factor for individuals who have been previously traumatized, but symptoms may be misunderstood and/or misdiagnosed, causing further distress. These symptoms can include, among others:

- Anxiety
- Numbing of affect
- Depression
- Dysphasia
- Cognitive
- Memory impairment
- Somatic complaints
- Flashbacks
- Sleep disturbance

It is clear that these symptoms, and the behaviors associated with them could, especially when considering the elderly, suggest a range of diagnoses, both psychiatric and physical, which could lead to treatment or interventions that might both overlook the underlying cause of the posttraumatic symptoms and hinder recovery.

Trauma and its effects have evolved over more than two decades and it is now widely known that "shocking events or lengthy periods of stress can cause serious damage to individuals' health".

Empirical research in neurobiology, psychopharmacology, and behavioral and social psychology points to the importance of understanding the causes and behaviors associated with trauma reactions, becoming familiar with the symptoms of Post-Traumatic Stress Disorder (PTSD) and applying the concepts and principles of trauma theory.

Trauma cuts across all boundaries of age, race, nationality, culture, gender and class. People with PTSD suffer from an inability to come to terms with real experiences that have overwhelmed their ability to cope. Exposure to extreme stress is widespread, and a substantial proportion of those exposed develop symptoms and behaviors characteristic of PTSD.

Recent studies of the incidence of exposure show that, for example, 76% of American adults said they had been exposed to extreme stress (Elliot & Briere, 1995); 9% of the population in a large North American city suffered from PTSD (Breslau & Davis, 1992); and more than 15% of Vietnam veterans continue to suffer from PTSD (Kulka et.al., 1990). The figures for other industrialized countries are compatible with those for the United States; data for the rest of the world are not available.

CONSIDERATIONS

Education: Education and consciousness-raising about trauma are key to ameliorating its effects. This should occur not only through training of agency personnel and health professionals, but through community efforts.

First, we can "depathologize" the person who is suffering from the effects of trauma and view our task as helping him or her to emerge from the after effects of incidents that would have been painful, terrifying or overwhelming to almost anyone.

Second, we need to recognize that there is much we can learn about "what happened" if we are aware of the characteristic ways in which the trauma is replayed and/or relived, whether communication is through words, behaviors, somatic phenomena, flashbacks, dissociation, or all of the above.

In fact, once the trauma is revealed, the affective, cognitive and somatic baggage that accompanied the original event will likely resurface. We need a repertoire of interventions that can serve to diminish anxiety and help the individual regain equilibrium.

Third, trust may be an issue, and the listener (relative, social worker, clergy, doctor, friend, senior center worker, volunteer, etc.) may have to tolerate descriptions of gory or horrific details of the original event in order to achieve it. The listener is in the position of "bearing witness" to a terrible, unspeakable experience.

Need for New Frameworks: The assumption that during senescence a person's physical and mental resilience gradually diminishes, leaving the trauma survivor less able to ward off or master repressed memories and feelings, is increasingly being questioned, but we lack conceptual models for assessing and explaining the effects of negative events on the elderly.

Nonetheless, if we misconstrue or ignore observable post-traumatic symptoms, we may well deny aging trauma survivors an empathic understanding of their sufferings and adequate treatment.

Similarly, confronting evidence of racism, war, prison camps, or cruelty, whether through direct experience or through the mass media may re-traumatize those who had experienced any of these situations earlier in life.

However, these are only triggers for memories of past trauma, not the cause of trauma. Reminiscence is critical in post-traumatic recovery, as a more active and controlled remembrance of traumatic events is a key to successful recovery from trauma.

Survivors of trauma have to mourn not only the losses that accompany old age, but also the many losses at the time of their traumatization that have not been worked through. Giving meaning to the traumatic experiences lessens distress, restores the sense of self control and fosters coherence and continuity of the self.

THE ELDERLY AND SUICIDE

Elderly Americans, sometimes sick, lonely and isolated, have the nation's highest rate of suicide at 50 percent greater than that for young people. Although researchers long have known that the elderly are at high risk for suicide, prevention has been difficult because the elderly seldom seek help.

Nursing home chaplains are bringing free counseling and support to the older Americans who have been identified as suicide risks by friends, family and the medical community.

Faith Based Chaplain volunteers have a proven track record of providing critical counseling to elderly people considering suicide. Older people who need help don't normally come to us, so they have found a way to go to them through a "ministry of presence".

There has not been a lot of funding or research for these types of programs and faith based chaplains have stepped in to offer faith based crisis counseling service as a component of the "ministry of presence" that is offered through many of the ministries today.

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Chaplains receive specialized training on issues facing the elderly and learn how to link older adults with resources and programs that can help them continue a peaceful existence.

It's extremely important that nursing home Chaplains gain as much knowledge as possible about each person they work with. There is a lot of knowledge to be gained but before that can happen there are certain things that they must do:

- Develop a rapport
- Gain their trust
- Be compassionate
- Be empathetic
- Listen and communication

For the faith based chaplain, visits and crisis counseling can and has improved the outlook of elderly participants. Most chaplains report a decrease in depression, increased social contact and fewer unmet personal needs.

It is usually a surprise to see how quickly elder individuals open up to a chaplain. The elderly person does not have to worry about being embarrassed or feel bad about their feelings and thoughts. They realize that the chaplain is there to help but most important, he/she is there to listen.

It is difficult to know how many elder individuals are truly on the verge of suicide, but a "ministry of presence chaplain" normally takes the time to explore whether proactive counseling could be effective in reaching elderly people at risk of suicide.

Person's over the age of 60 who has unmet needs of daily living or problems with isolation and depression is generally the ones that the chaplains counsel because their goal is to help people before they get to the point of considering suicide.

ELDERLY SUICIDE FACT SHEET

- While the elderly make up only 12.6% of the population, they account for almost 18.1% of the suicides.
- There is one elderly suicide every one hour thirty-nine minutes.
- The suicide rate for the elderly rose 9% between 1980 and 1992. During that time, there were 74, 675 completed suicides of persons over 65. Rates have declined since that time.
- In 2000, suicide rates ranged from 12.6 per 100,000 among persons aged 65 to 74, to 17.7 per 100,000 persons aged 75 to 84, which is nearly double the overall U.S. rate.
- White men over the age of 85 are at the greatest risk of all age-race groups. In 1999, the suicide rate for these men was 59.6 per 100,000. That is nearly 6 times the current overall rate.

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- 84% of elderly suicides are men; the number of men's suicides in late life is 5 times that for women (men's rates are 7.6 times those of women).
- The rate of suicide for women declines after age 60 (after peaking in middle adulthood, age 40-54).
- Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate. The elderly are more lethal in their attempts and complete suicide more often.
- For all ages combined, there is 1 suicide for every 20 attempts. Among the young (15-24 years) there is 1 suicide for every 100-200 attempts. Over the age of 65, there is 1 suicide for every 4 attempts.
- Firearms are the most common means of completing suicide among the elderly.
- Men (78%) use firearms more than twice as often as women (35%).
- Alcohol or substance abuse plays a diminishing role in later life suicides.
- Contrary to popular opinion, only a fraction (2-4%) of suicide victims has been diagnosed with a terminal illness at the time of their death.
- Two-thirds of older adults in their late 60's, 70's and 80's were in relatively good physical health when they died by suicide.
- 20% of elderly suicides over 75 have been seen by a physician within 24 hours of completing suicide; 35% have been seen by a physician within a week; 75% have seen a primary care physician within a month of their suicide; and 80% have seen a primary care physician within 6 months of their suicide.
- 66%-90% of elderly suicides have at least one psychiatric diagnosis. Two-thirds of these diagnoses are for late-onset, single episode clinical depression.
- As many as 75% of depressed older Americans are not receiving the treatment they need, placing them at an increased risk of suicide.
- Elderly persons are less likely to reach out by calling a crisis line than their younger counterparts.
- Suicide rates are highest in the mountain states of the United States for the nation as a whole and the elderly.

MYTHS

- Depression among the elderly is a normal consequence of aging and associated problems.
- Depression among the elderly cannot be treated.
- Most completed suicides are terminally ill.
- Elders who complete suicide do not have close family members.
- Only elderly persons who live alone are at risk for suicide.
- Suicide and suicidal behavior are normal responses to stresses experienced by most people.
- There is nothing that can be done to stop an elderly suicide.
- Most suicidal elders will self-refer to obtain mental health care.
- Suicidal elderly do not exhibit warning signs of their suicidal ideation or intent.
- Adverse living conditions are not significant risk factors in elderly suicide

FACTS BASED ON RESEARCH FINDINGS

- Although there are no official statistics on attempted (e.g., non-fatal actions suicide) it is generally estimated that there are at least 8 to 20 attempts for each death by suicide.
- Risk of attempted (nonfatal) suicide is greatest among females and the young.
- Females have generally been found to make 3 to 4 times as many attempts as males.
- Ratios of young attempted suicides to suicide deaths generally range between 100 to 1 and 200 to 1.
- Mental health diagnoses are generally associated with a higher rate of suicide.
- Groups/diagnosis at particular risk include: depression, schizophrenia, and drug and/or chemical dependency, and panic disorders.
- Feelings of hopelessness (e.g., there is no solution to my problem) are found to be more predictive of suicide risk than a diagnoses of depression per se.
- The socially isolated are generally found to be at high risk of suicide.
- The vast majority of individuals who are suicidal often display clues and warning signs.

OTHER ISSUES

The designation of “survivor of suicide” refers to the family members and friends who remain alive following the death of their loved on by suicide. It is not known how many survivors there are, but conservative estimates indicate that there are at least 4.4 million Americans who are survivors of suicide.

UNREPORTING OF SUICIDES

Minimum estimates of suicides among the elderly in the United States range from 6000 to 10,000 annually. Often these suicides are not reported as such but are listed as accidental deaths. Many are committed by isolated, lonely, older people.

In some cases, there are no friends or family members who care about the person's cause of death; in other cases, they may be too afraid to inquire because of the stigma attached to this kind

of death. Additionally, suicides are often mistaken for natural deaths, especially in cases of medicinal overdosing, because many older people take several medications.

SUICIDE ATTEMPTS

For elderly people, the ratio of attempts to completed suicides is 4 to 1 compared to younger persons. Thus, an older person who contemplates suicide is more likely to complete the act.

There are several reasons for this fact. First, as mentioned previously, elderly people often employ lethal methods when attempting suicide. Second, older people experience greater social isolation. Finally, the elderly generally have poorer recuperative capacity, which make them less likely to recover from a suicide attempt.

RECURRENT TRAUMA AND DEPRESSION

Elderly people who have experienced a trauma are at least three times more likely to experience recurrent trauma, and older patients, 70 years old and older, who have been hospitalized for an injury are at significantly higher risk for a subsequent injury, those at greatest risk are women and those with chronic medical conditions or functional impairments.

Injury risk among the growing elderly population in this country represents a significant public health concern. Trauma among elderly patients has a tremendous impact on health care expenses and their quality of life, and as this population continues to increase, so does the importance of this public health issue and the need to stricter elderly care.

The study analyzed data from the Longitudinal Study of Aging, an extension of the National Health Interview Survey, conducted from 1984 to 1990. Information was derived from the National Death Index, Medicaid hospital records and Medicare records of 16,148 non-institutionalized elderly people living in the United States during that time.

Findings may have a direct impact on injury prevention initiatives aimed at elderly people and those likely to have repeat incidences of trauma. “By providing elderly patients with education and counseling during their initial hospitalization, the likelihood of recurrent trauma will be reduced.

The study found that functional impairments are the strongest indicator of injury recurrence. “Patients who reported greater difficulty with daily activities such as bathing, dressing and eating as a result of their first injury were more likely to suffer another injury. “This means that interventions aimed at reducing the impact of injury on functional status are likely to have an effect on the risk of another injury.”

In other instances, research has proven beneficial in influencing prevention efforts, specifically in regard to the link between recurrent trauma and alcohol use. “Interventions implemented in a younger age group resulted in a significant decline in alcohol-related injuries. More research among older adults is needed to have an impact on recurrent trauma among this age group.

The difficult changes that many elderly individuals face—such as the death of a spouse or medical problems—can lead to depression, especially in those without a strong support system. But depression is not a normal or necessary part of aging. In fact, most seniors are satisfied with their lives despite the challenges of growing old.

Left alone, depression not only prevents older adults from enjoying life like they could be, it also takes a heavy toll on health. But if you learn how to spot the signs of depression and find effective ways to help, you or your loved ones can remain happy and vibrant throughout the golden years.

DEPRESSION AND THE ELDERLY

- Depression is a problem for many older adults
- Causes of depression in the elderly
- Signs and symptoms of depression in the elderly
- Helping a depressed friend or relative
- Depression self-help for seniors
- Getting professional help for depression
- Treatment options for the elderly
- Dementia vs. depression
- Depression is a problem for many older adults

Loss is painful, whether a loss of independence, mobility, health, your long-time career, or someone you love. Grieving over these losses is normal, even if the feelings of sadness last for weeks or months. Losing all hope and joy, however, is not normal. It's depression.

According to the National Institutes of Health, of the 35 million Americans age 65 or older, about 2 million suffer from full-blown depression. Another 5 million suffer from less severe forms of the illness.

Although depression in the elderly is a common problem, only a small percentage gets the help they need. There are many reasons depression in older adults is so often overlooked: Some assume seniors have good reason to be down or that depression is just part of aging.

Elderly adults are often isolated, with few around to notice their distress. Physicians are more likely to ignore depression in older patients, concentrating instead on physical complaints. Finally, many depressed seniors are reluctant to talk about their feelings or ask for help.

The consequences of this oversight are high. Untreated depression poses serious risks for older adults, including illness, alcohol and prescription drug abuse, a higher mortality rate, and even suicide. So it's important to watch for the warning signs and seek professional help when you recognize it. The good news is that with treatment and support, depressed seniors can feel better.

CAUSES OF DEPRESSION IN THE ELDERLY

Many elderly adults face significant life changes and stressors that put them at risk for depression. Those at the highest risk include:

- Older adults with a personal or family history of depression
- Failing health
- Substance abuse
- Inadequate social or family support
- Loneliness and isolation
- Decreased mobility due to illness or loss of driving privileges.
- Reduced sense of purpose
- Medications
- Fears
- Recent bereavement - The death of friends, family members, and pets; the loss of a spouse or partner.

IS IT GRIEF OR DEPRESSION?

Although a grieving person may experience a number of depressive symptoms such as frequent crying and profound sadness, grief is a natural and healthy response to bereavement and other major losses.

There is a difference, however, between a normal grief reaction and one that is disabling or unrelenting. While there's no set timetable for grieving, if it doesn't let up over time or extinguishes all signs of joy, laughing at a good joke, brightening in response to a hug, appreciating a beautiful sunset, it may be depression.

SIGNS AND SYMPTOMS OF DEPRESSION IN THE ELDERLY

Recognizing depression in the elderly starts with knowing the signs and symptoms. Depression red flags include:

- Sadness
- Fatigue
- Abandoning or losing interest in hobbies or other pleasurable pastimes
- Social withdrawal and isolation (reluctance to be with friends, engage in activities, or leave home)
- Weight loss; loss of appetite
- Sleep disturbances (difficulty falling asleep or staying asleep, oversleeping, or daytime sleepiness)
- Loss of self-worth (worries about being a burden, feelings of worthlessness, self-loathing)
- Increased use of alcohol or other drugs
- Fixation on death; suicidal thoughts or attempts
- Depression without sadness

Older adults don't always fit the typical picture of depression. Many depressed seniors don't claim to feel sad at all.

They may complain, instead, of low motivation, a lack of energy, or physical problems. In fact, physical complaints, such as arthritis pain or headaches that have gotten worse, are often the predominant symptom of depression in the elderly.

Older adults with depression are also more likely to show symptoms of anxiety or irritability. They may constantly wring their hands, pace around the room, or fret obsessively about money, their health, or the state of the world.

SUICIDE AND DEPRESSION CLUES

Older adults who deny feeling sad or depressed may still have major depression. While these are some clues that are considered “normal” for most depressed elderly people, there will be that vast few that can act opposite from the normal population.

Clues to look for:

- Unexplained or aggravated aches and pains
- Hopelessness
- Helplessness
- Anxiety and worries
- Memory problems
- Loss of feeling of pleasure
- Slowed movement
- Irritability
- Lack of interest in personal care (skipping meals, forgetting medications, neglecting personal hygiene)
- They often give personal items away
- They go on a spending spree
- They want to stay close to family or friends
- Travel to see family and friends they haven't seen in many years
- Make phone calls to tell people that they love them (they are saying good bye)
- Will purchase guns, weapons etc
- Will make sure wills and legal papers are in order

HOWEVER, for those few that may act opposite, these clues may apply:

- Avoidance
- Appear too happy after a prolonged sadness
- Appear to be well, after complaining of aches and pains
- Feel the need to spend money on repairs and large items
- Have the need take care of personal appearance (hair-cuts, nails, pedicures etc.)
- Females have the tendency to clean house, buy food and necessities

HELPING A DEPRESSED FRIEND OR RELATIVE

The very nature of depression interferes with a person's ability to seek help, draining energy and self-esteem.

For depressed seniors, raised in a time when mental illness was highly stigmatized and misunderstood, it can be even more difficult especially if they don't believe depression is a real illness, are too proud or ashamed to ask for assistance, or fear becoming a burden to their families. With such roadblocks, assistance from others can mean the difference between suffering and recovery.

If a senior citizen you care about is depressed, you can make a difference by offering emotional support. Listen to your loved one with patience and compassion. Don't criticize feelings expressed, but point out realities and offer hope.

You can also help by seeing that your friend or family member gets an accurate diagnosis and appropriate treatment. Help your loved one find a good doctor, accompany him or her to appointments, and offer moral support.

OTHER TIPS FOR HELPING A DEPRESSED ELDERLY

Invite your loved one out. Depression is less likely when people's bodies and minds remain active. Suggest activities to do together that your loved one used to enjoy: walks, an art class, and a trip to the museum or the movies, anything that provides mental or physical stimulation.

Schedule regular social activities: Group outings, visits from friends and family members, or trips to the local senior or community center can help combat isolation and loneliness. Be gently insistent if your plans are refused: depressed people often feel better when they're around others.

Plan and prepare healthy meals. A poor diet can make depression worse, so make sure your loved one is eating right, with plenty of fruit, vegetables, whole grains, and some protein at every meal.

Encourage the person to follow through with treatment. Depression usually recurs when treatment is stopped too soon, so help your loved one keep up with his or her treatment plan. If it isn't helping, look into other medications and therapies.

Make sure all medications are taken as instructed. Remind the person to obey doctor's orders about the use of alcohol while on medication. Help them remember when to take their dose. Watch for suicide warning signs. Seek immediate professional help if you suspect that your loved one is thinking about suicide.

DEPRESSION SELF-HELP FOR SENIORS

Isolation and inactivity only make depression worse. The more active they are, physically, mentally, and socially, the better you'll feel.

SOME WAYS TO COMBAT AND PREVENT DEPRESSION INCLUDE:

- Getting out in to the world – Try not to stay cooped up at home all day. Go to the park, take a trip to the hairdresser, or have lunch with a friend.
- Connecting to others – Limit the time you're alone. If you can't get out to socialize, invite loved ones to visit you, or keep in touch over the phone or email.
- Participating in activities you enjoy - Pursue whatever hobbies or pastimes bring or used to bring you joy.
- Volunteering your time – Helping others is one of the best ways to feel better about yourself and regain perspective.
- Taking care of a pet – Get a pet to keep you company.
- Learning a new skill – Pick something that you've always wanted to learn, or that sparks your imagination and creativity.
- Enjoying jokes and stories – Laughter provides a mood boost, so swap humorous stories and jokes with your loved ones, watch a comedy, or read a funny book.
- Maintaining a healthy diet – Avoid eating too much sugar and junk food. Choose healthy foods that provide nourishment and energy, and take a daily multivitamin.
- Exercising - Even if you're ill, frail, or disabled, there are many safe exercises you can do to build your strength and boost your mood—even from a chair or wheelchair.

GETTING PROFESSIONAL HELP FOR DEPRESSION

While support and self-care can help depressed seniors, professional help should also be pursued. If you see the signs and symptoms of depression in yourself or an older relative, schedule an appointment with a doctor for a thorough evaluation, including a complete physical and lab workup. This is particularly important since many medical conditions, medications, and even certain physiological changes of aging can cause depression or compound the problem.

ILLNESS AND DEPRESSION

When undergoing evaluation for depression, long-term or severe health issues should also be taken into account. Chronic medical conditions, particularly those that are painful, disabling, or life-threatening, can understandably lead to depression. Illnesses that affect the brain can also cause depression through the disease process itself.

Medical conditions that commonly trigger depression include:

- Heart attack or disease
- Parkinson's disease
- Stroke

- Alzheimer's
- Multiple sclerosis
- Cancer
- Diabetes

MEDICATION-INDUCED DEPRESSION

All medications have side effects, but some can actually cause symptoms of depression or make a pre-existing depression worse. Harmful drug interactions or a failure to take a medication as prescribed can also contribute to depression. For elderly individuals with multiple prescriptions, the risk of medication-induced depression is particularly high.

The chaplain should always make sure that the elderly person he/she they are about to counsel with is not depressed due to medication.

MEDICATIONS THAT CAN INDUCE DEPRESSION INCLUDE:

- Steroids
- Painkillers
- Hormones
- Arthritis medication
- High blood pressure drugs
- Heart disease medication
- Tranquilizers
- Cancer drugs

TREATMENT OPTIONS FOR THE ELDERLY

Depression treatment is just as effective for elderly adults as it is for younger people. Therapy, support groups, Crisis intervention counseling and medication can all help relieve symptoms. However, health issues should always be considered in an older adult's treatment plan.

Any medical issues complicating the depression must be addressed and resolved. For example, many seniors suffer from chronic pain. Pain that interferes with daily activities can prevent depression recovery, so it must be managed as part of the treatment plan.

ANTIDEPRESSANT TREATMENT

Antidepressant medications can ease depression in the elderly. But older adults are more sensitive to drug side effects and vulnerable to interactions with other medicines they're taking.

COUNSELING AND THERAPY

Therapy or counseling works just as well as medication in relieving depression. And unlike medication, therapy or counseling also addresses the underlying causes of the depression.

- Supportive counseling includes religious and peer counseling. It can help ease loneliness and the hopelessness of depression.
- Psychotherapy helps people work through stressful life changes, heal from losses, and process difficult emotions.
- Cognitive behavioral therapy (CBT) helps people change negative thinking patterns, deal with problems in healthy ways, and develop better coping skills.
- Support groups for depression, illness, or bereavement connect people with others who are going through the same challenges. They are a safe place to share experiences, advice, and encouragement.

DEMENTIA VS. DEPRESSION

Never assume that a loss of mental sharpness is just a normal sign of old age. It could be a sign of depression or dementia, both of which are common in the elderly. But since depression and dementia share many similar symptoms, including memory problems, sluggish speech and movements, and low motivation, it can be difficult to tell the two apart. There are, however, some differences that can help you distinguish between the two.

IS IT DEPRESSION OR DEMENTIA?

Symptoms of Depression Symptoms of Dementia:

- Mental decline is relatively rapid
- Knows the correct time, date, and where he or she is
- Difficulty concentrating
- Language and motor skills are slow, but normal
- Notices or worries about memory problems
- Mental decline happens slowly
- Confused and disoriented; becomes lost in familiar locations
- Difficulty with short-term memory
- Writing, speaking, and motor skills are impaired
- Doesn't notice memory problems or seem to care

Whether the cognitive decline is caused by dementia or depression, prompt diagnosis and treatment are key. If it's depression, memory, concentration, and energy will bounce back with treatment. Treatment for dementia will also improve you or your loved one's quality of life. And in some types of dementia, symptoms can be reversed, halted, or slowed.

Traumatic events can occur at any point or during any period of the life cycle: some individuals may undergo long periods of traumatic stress, such as that experienced in combat or in prisoner-

of-war camps; others may experience only one incident, such as a rape, or the Oklahoma City bombing.

There is some evidence to suggest that early, repetitive trauma such as that experienced by children growing up in an abusive family may have permanent developmental effects, leaving the individual vulnerable throughout the life span. Though reactions to traumatic events can vary widely among individuals, there is some evidence that as external and internal resources diminish in later life, prior trauma may renew its hold.

Consequently, delayed onset, reemergence, or exacerbation of symptoms and behaviors associated with posttraumatic stress may appear during the aging process. Indeed, aging may prove to be a risk factor for individuals who have been previously traumatized, but symptoms may be misunderstood and/or misdiagnosed, causing further distress.

These symptoms can include, among others, anxiety, numbing of affect, depression, dysphasia, cognitive and memory impairment, somatic complaints, flashbacks and sleep disturbance. It is clear that these symptoms, and the behaviors associated with them could, especially when considering the elderly, suggest a range of diagnoses, both psychiatric and physical, which could lead to treatment or interventions that might both overlook the underlying cause of the posttraumatic symptoms and hinder recovery.

The study of trauma and its effects has evolved over more than two decades and it is now widely known that "shocking events or lengthy periods of stress can cause serious damage to individuals' health" (Aarts & Op den Velde, 1996).

Empirical research in neurobiology, psychopharmacology, and behavioral and social psychology points to the importance of understanding the causes and behaviors associated with trauma reactions, becoming familiar with the symptoms of Post-Traumatic Stress Disorder (PTSD) and applying the concepts and principles of trauma theory.

Trauma cuts across all boundaries of age, race, nationality, culture, gender and class. People with PTSD suffer from an inability to come to terms with real experiences that have overwhelmed their ability to cope. Exposure to extreme stress is widespread, and a substantial proportion of those exposed develop symptoms and behaviors characteristic of PTSD.

Recent studies of the incidence of exposure show that, for example, 76% of American adults said they had been exposed to extreme stress (Elliot & Briere, 1995); 9% of the population in a large North American city suffered from PTSD (Breslau & Davis, 1992); and more than 15% of Vietnam veterans continue to suffer from PTSD (Kulka et.al., 1990). The figures for other industrialized countries are compatible with those for the United States; data for the rest of the world are not available.

Physical activity and nutrition: Research indicates that staying physically active can help prevent or delay certain diseases, including some cancers, heart disease and diabetes, and also relieve depression and improve mood.

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Inactivity often accompanies advancing age, but it doesn't have to. Check with your local churches or synagogues, senior centers, and shopping malls for exercise and walking programs. Exercise and eating habits are often not good if they live and eat alone. It's important for successful aging to eat foods rich in nutrients and avoid empty calories in candy and sweets.

Overweight and obesity. Being overweight or obese increases your chances of dying from hypertension, , type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, dyslipidemia and endometrial, breast, prostate, and colon cancers.

Tobacco: Tobacco is the single greatest preventable cause of illness and premature death in the U.S. Tobacco use is now called "Tobacco dependence disease." The Center for Disease Control (CDC) says that smokers who try to quit are more successful when they have the support of their physician.

Substance abuse: Substance abuse usually means drugs and alcohol. These are two areas we don't often associate with seniors.

But seniors, like young people, may self-medicate using legal and illegal drugs and alcohol which can lead to serious health consequences. In addition, seniors may deliberately or unknowingly mix medications and use alcohol. Because of our stereotypes about senior citizens, many medical people fail to ask seniors about possible substance abuse.

HIV/AIDS: Between 11 and 15% of U.S. AIDS cases occur in seniors over age 50. Between 1991 and 1996, AIDS in adults over 50 rose more than twice as fast as in younger adults. Seniors are unlikely to use condoms, have immune systems that naturally weaken with age, and HIV symptoms (fatigue, weight loss, dementia, skin rashes, and swollen lymph nodes) are similar to symptoms that can accompany old age. Again, stereotypes about aging in terms of sexual activity and drug use keep this problem largely unrecognized. That's why seniors are not well represented in research, clinical drug trials, prevention programs and efforts at intervention.

Mental health: Dementia is not part of aging. Dementia can be caused by disease, reactions to medications, vision and hearing problems, infections, nutritional imbalances, diabetes, and renal failure.

There are many forms of dementia (including Alzheimer's disease) and some can be temporary. With accurate diagnosis come management and help. The most common late-in-life mental health condition is depression. If left untreated, depression in the elderly can lead to suicide.

Here's a surprising fact: the rate of suicide is higher for elderly white men than for any other age group, including adolescents.

Injury and violence: Among seniors, falls are the leading cause of injuries, hospital admissions for trauma, and deaths due to injury. One in every three seniors (age 65 and older) will fall each year.

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Strategies to reduce injury include exercises to improve balance and strength and medication review. Home modifications can help reduce injury.

Home security is needed to prevent intrusion. Home-based fire prevention devices should be in place and easy to use. People aged 65 and older are twice as likely to die in a home fire as the general population.

Environmental quality: Even though pollution affects all of us, government studies have indicated that low-income, racial and ethnic minorities are more likely to live in areas where they face environmental risks. Compared to the general population, a higher proportion of elderly are living just over the poverty threshold.

Immunization: Influenza and pneumonia are among the top 10 causes of death for older adults. Emphasis on Influenza vaccination for seniors has helped. Pneumonia remains one of the most serious infections, especially among women and the very old.

Access to health care: Seniors frequently don't monitor their health as seriously as they should. While a shortage of geriatricians has been noted nationwide, Strong Health has one of the largest groups of geriatricians and geriatric specialists of any medical community in the country.

NOTES

CHAPTER 15 HOW TO PLAN A MINISTRY PROGRAM

This manual is designed to offer help to chaplains who wish to start a nursing home ministry with helping them both inside and outside to organize the needs of the elderly.

In the past, it was left up to the churches to minister to the aged. Today many churches are re-examining their efforts due to a bigger demand for pastoral counselors and chaplains. As concern for the aged has increased, so too have the resources available to pastors and chaplains everywhere.

Health systems, social organizations, pastors and chaplains stand ready to provide support for the aging and disabled and are taking on new projects or otherwise equipping themselves for a ministry of presence for the aged.

This goal of this portion of the manual is to provide general guidelines on how to plan a program and to serve the aged and disabled. It offers you suggestions about how to plan different types of programs to help organize and maintain an effective volunteer chaplain program.

Detailed instructions have necessarily been omitted due to the fact that program development and implementation will vary according to nursing home policy and procedures. This information is offered as a suggestion only.

HOW TO PLAN A PROGRAM

Develop a planning committee: Organize a committee responsible for looking into program ideas and developing a plan to extend to a ministry designed for the ageing. The committee should consist of a pastor, head chaplain members of your church or a church willing to participate and members of staff or the church that are willing to be involved.

It is recommended that older people be recruited for this committee. The goals of the committee are to survey the needs and resources, define the problems associated with the ministry, develop plans for problem resolution, work to initiate programs, review the problems in the light of program impact and make appropriate program adjustments.

Survey the needs: before a ministry program can be developed, the chaplain and nursing home staff, pastors and elderly must understand the needs and un-met needs of the elderly in the nursing home and in the community.

Interviews with local officials, nursing home staff, staff from neighborhood health and welfare organizations and other health care delivery systems and area agency on aging should help.

Get suggestions for programs: There are many ideas for possible programs. Plan a way to involve as many of the person's involved, elderly person's and community members who may wish to be involved for ideas and discuss approaches to the problems that have been discovered.

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Choose a strategy: There are two basic strategies which might be used.

1). Develop a link with existing program in your area serving the aged.
2). Establish a new program, such as a Senior Club or Friendly Visiting Program using a church or a nursing home as a base. This approach will involve greater expenditures of time, and personnel resources. However, this type of an approach will bring a greater satisfaction to every elderly person who will benefit from this program.

- When planning your approach, the planning committee will need to consider the following factors:
- What is the mission of the church or private ministry? Will this program work?
- What resources do I need and how will I get them. What type of resources will I need?
- Where can I do this? Do they have proper facilities that will be available?
- Will the program conflict with other activities?
- How will the non-residents get to the facility?
- What equipment and supplies do I need and are they available?
- What is the financial situation of me, the church or the nursing facility?
- What skills and interest to the people involved have?
- What groups might be interested?

Write a plan: After focusing on the factors and making a decision on the approach, the committee should draw up a “workable” plan. Just remember the plan must be workable or it will never work to your advantage. The plan should include the following components:

- Goals
- Specific objectives
- Organization objectives
- A task list
- How will this be accomplished?
- A list of the target population and who will be involved
- Costs
- Members and what their responsibilities are and who will be accountable

Start out on a small scale and leave room for growth. Increase as necessary and as strengths and weaknesses become evident and as more of the elderly become interested. It would benefit the program to have a way for the elderly to be able to make suggestions or comments about the program.

Don't take it personally due to the fact that for those involved are the very person's affected by the outcome. However, remember that there is no way to ever please everyone so pick and choose your battles there.

Plan a fundraiser if necessary. There are churches, organizations and private citizens who will willingly get involved if they get the chance. Assign someone to organize the activities.

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It is important to set up checkpoints for evaluations to see how the program is functioning. Reviews will enable you to make modification to plans, based on experience. Make sure that all aspects of the program are being implemented in proper sequence and to make sure that the plan is accomplishing what it was set out to do.

VOLUNTEER PROGRAMS

Coordination and Supervision: Someone must take responsibility for tasks, activities, record keeping and accounts. Depending on the program, functions may be handled by a small committee or a single member, by volunteers or paid staff from a church or organization.

Supervision is crucial in volunteer programs. Each person or group should be supervised by a person who can provide ongoing support, recognize the need for further training and help when problems arise.

Recruiting Volunteers: There are many people who would volunteer (citizens, church members, retirees, or the elderly themselves) but most people don't hear about these programs. Announcements, newsletters, notices, bulletins, and personal contacts are a good resource for recruiting volunteers. When you announce the program, there are things that you should say:

- What the program is
- Who it will benefit
- What is involved (specific tasks)
- How much time they will be required to be involved

Each volunteer should be given a choice of activities to tailor the activities that each may be good at or may have a special skill in. If groups are involved, activities will need to be scheduled in the late afternoon and early evening hours.

Volunteer Training: Once a group of volunteers have been established, training should be provided. The subjects that need to be covered are:

- Issues related to aging
- The overall program
- Problems associated with the program
- Specific tasks

Involve role playing and pass out a written description of what he/she is expected to do and a contact list of those designated to answer any questions they may have. A volunteer contract can be a useful tool for specifying basic standards of performance and lines of accountability.

It should be expected that a certain percentage of volunteers will drop out shortly after it starts.

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There are many reasons for this: When a volunteer drops out of the program there are many reasons. A change in one's personal situation which makes volunteering inconvenient, misunderstandings, or performance anxiety or they may feel that they don't want to do it at all, just because.

Always follow-up with that volunteer, particularly those whose enthusiasm seems to be missing. Sometimes support is all that is needed. In other cases the volunteer may be more comfortable with another task.

Never take volunteers for granted. Continuing support is a necessity. Help to maintain the individual's enthusiasm and be sure to give them the recognition for the valuable work that they do. Offer to help them in all that they do and give supervision when needed. Let the person "be" involved and let them know that their opinion counts.

Recognition: Normally, people won't do something for nothing. There are those who required only self satisfaction from helping someone else but there are those who want to be recognized. There are many ways to recognize their work and efforts:

- Dinners
- News letters
- News papers
- Bulletins
- Displays
- Community
- Church

Make sure that when you recognize a volunteer, you are sincere!

IDEAS FOR PROGRAMS

Spot light the elder first: for nursing home residents or elderly church or community person's there are things to assess first:

1. Are the elderly members of the community, church or nursing home attending church or activities regularly? If not, why not.
2. How are the older members of the nursing home, community or church made to feel wanted? Are they encouraged to serve on committees or boards?
3. Do activities appear to be age-segregated? How can I help people of all ages interact with one another in a meaningful way?
4. Is the location, ramps or restrooms accessible for the elderly and the disabled?
5. Is the location equipped for the hearing or sight impaired?
6. Are topics or activities something that the elderly are interested in?
7. Are there workshops available for getting to know the elderly and their concerns.
8. Is death, grief or crisis counseling available?

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Visitation program: Set up visits for the volunteers and the older person either in their homes or the nursing home. The objective of the program is to:

- Relieve loneliness
- Build long-term friendships
- Find out about interests and activities they are interested in
- Help them utilize resources

Weekly visits can build lifetime friendships and the elderly person can become a more active member of the home or society with support from a person that cares. To arrange a visit program, contact a supervisor or coordinator and ask if they will help you with names of the persons that may be interested.

The supervising chaplain is responsible for training, matching the elderly with visitors, preparing the visitor by sharing important information and the person (s), accompanying the visitor on the initial visit, and providing follow-up support.

A visitor program should be an hour or two each week. Time talking, reading, assisting with letter writing, playing games or just “being there” are a good activities to start with. The visitor should report any problems or situations of stress or need to his or her supervisor so that a referral can be made to obtain needed help.

Telephone reassurance program:

A telephone reassurance program is a good way of linking volunteers with older adults. It relieves loneliness and helps to develop friendships. It will assist in checking on health issues or safety issues that the elderly adult may have encountered since the last talk or visit.

The telephone conversation does not have to be long, just a short brief conversation should be all that is necessary. However, if you make a call and you get no answer, you should take immediate steps to have emergency personnel check on the person. It will assure the elderly person that if he/she should be hurt or ill and unable to call for assistance that someone will be able to know something is wrong and help will be sent.

Personal assistance program: A personal assistance program for older people is simply that. It is a way of arranging for volunteers to help the elderly with difficult tasks. Some examples of assistance that might be provided are as follows:

- Doctor appointments
- Dentist appointments
- Grocery shopping
- Gathering medication from pharmacy
- Paying bills
- Check writing
- Banking
- Prepare meals

- Laundry
- cleaning
- Mowing
- Fixing broken appliances

REQUIREMENT FOR A PERSONAL ASSISTANCE PROGRAM

Detective work:

1. Find out what needs to be done and offer helpful assistance to older people who might be reluctant about asking.
2. Attempt to recruit groups such as boy scouts, retired persons, and community volunteers
3. A coordinator, responsible for matching requests for assistance willing to provide it.
4. Publicity to advertize.

Adopt-A-Grandparent Program: This is based on the idea that younger people and older people need one another, and that each role is important for the growth and development of other family members.

Many families live in different parts of the country, too far to interact with one another on a regular basis. In other families, significant family members have died, leaving gaps in the family system.

In an Adopt-A-Grandparent Program: Younger families and older adults are matched up with one another and establish a relationship similar to that between grandparents and natural families. Such a relationship might include interaction including frequent telephone contacts and visits, shared holiday and birthday celebrations, and a pattern of reciprocal services that family members perform for one another.

How to set up the program:

1. Identify older adults and younger families who wish to participate in the program.
2. Match them up and arrange for them to meet one another. Make sure that people are compatible and share significant interests and values.
3. Make sure both have a chance to decide whether or not they wish to “adopt” each other.
4. Assist in the development of a mutually satisfying relationship. Not all older adults have been parents or natural grandparents.

It may also be possible to institute an Adopt-A-Grandparent relationship with older people in a nursing home or extended care facility. Discuss the program with an administrator and work out details of transportation, meals, visiting, etc. Families and potential grandparents must share common expectations for the program.

As both the young children and older person spend more time with each other, there is an adoption that will take place naturally.

Adopt-A-Home Nursing Home: Nursing home Institutions and long-term care facilities are institutions out of the mainstream of thought and activity of the regular community. Residents of these facilities are unable to get out and participate in normal activity; many suffer from enforced social and cultural isolation.

We, as chaplains do not have to let it remain this way. The option to bring the outside world in through the efforts of the nursing home, community, churches and ourselves have the potential to bring these changes for every elderly person in need. However, involvements will vary according to each particular need and availability of resources.

Programs should be set up and organized with the administrator. Consistence of commitment is a key to ingredient to program success.

Guardianship: If an elderly person becomes incompetent and unable to carry on with their own affairs and doesn't have anyone available to make necessary decisions for care, it may become necessary for them to legally establish a guardianship.

There are two forms of guardianship:

A guardian of the person: It is a person who is responsible for making decisions regarding the personal welfare and well-being of another such as where the person will live, or if nursing home care would be necessary.

A guardian of the estate: An individual responsible for making decisions regarding the estate and financial situation of another to further that person's well-being.

Because the guardian of the estate can receive a percentage of the estate in return for providing management, it is often possible to arrange for a bank, lawyer or insurance firm to take on this responsibility, if there are significant assets involved.

However, many older people have little more than a few personal items and a monthly social security check and it is very difficult to find persons willing to take on that type of responsibility for managing these assets. It is possible for one person to assume guardianship of both the person and the estate.

The need for a caring, responsible adult to serve as a guardian is great. Chaplains, churches or a private individual must be willing to step in and assume this role.

To be a guardian, one must accept a permanent relationship of responsibility for another. Accurate records and financial transactions must be kept to weigh the needs of the individual when making decisions and one must be accountable in court. The guardian must serve both functions as advocate and caretaker.

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Transportation Assistance Program: This is another means of linking volunteers with older adults to provide a variety of services for Doctor Visits, hospital, therapists, church, shopping, etc. to establish a transportation assistance program, you must have a coordinator, a client group and volunteer drivers.

There are several ways that this program can operate depending on the coordinator's style, the needs of the group and the number of volunteers.

A system for requests should be put into place and requests should be made several days in advance. Depending on location, number of people and geographic areas should be considered.

Volunteers and Chaplains should register with the coordinator, specifying date and times they are available. The chaplain coordinator should be the one who makes necessary arrangements with volunteers and residents.

Senior Citizen Clubs: a Senior Citizen Club is a group of people who get together to perform some tasks and/or social or emotional reasons. These clubs function to provide interaction, social support and fun.

It has been noted by churches and nursing homes that have implemented this program that Senior Groups can be an effective means of preventing and resolving isolation and its attendant problems.

Providing a place for social contacts and friendships effects self esteem in various ways. It helps to get the elderly re-involved in society and social functions. It has provided a way for elderly persons to not only develop new skills but to help develop skills in other.

To establish a Senior Club:

- Determine how many older elderly need help
- Determine the type of help needed
- Provide leadership
- Set an agenda
- Provide a speaker and coordinator
- Provide direction

CONCLUSION

Starting a nursing home ministry is not only needed but necessary. The chaplain who attempts to build a ministry in a nursing home will have to have the Lord in their lives every day, they will also have a lot of responsibility and will have to dedicated, compassionate with empathy.

To start a nursing home ministry is not only a lot of hard work but it takes a special person who has the dedication through Jesus Christ our Lord to learn, study, and do what God tells us to do.

RESOURCES

HABER, C., and GRATTON, B. *Old Age and the Search for Security*. New York: Cambridge University Press, 1994

Eternal Word Television Network 5817 Old Leeds Road Irondale, AL 35210

Michael Monheit, Attorney at Law, Rydel PA.

The World Assembly on Ageing, August 1982.

JOURNAL OF PALLIATIVE MEDICINE Volume 5, Number 2, 2002 © Mary Ann Liebert, Inc.

The National Crime Victimization Survey reports (Bureau of Justice Statistics, 2001).

The Administration on Aging, 2000.

The National Center on Elder Abuse, 1998.

Elliot & Briere, 1995); (Breslau & Davis, 1992); (Kulka et.al., 1990 The National PTSD counsel.

The Longitudinal Study of Aging, an extension of the National Health Interview Survey, conducted from 1984 to 1990.

Chaplain Fellowship Ministries International, Inc. Nursing Home Chaplains Manual (2001)



Nursing Home Chaplain Certification



What Do You Know About Aging

Growing old is an experience almost everyone will have. Today, 1 out of 9 people in the United States is 65 or older, and the fastest growing age group is people 85 and older.

What does "being old" mean to you? Our beliefs shape how we age and how we relate to older people. Is what you know about aging based on facts or on myths?

The later years of life often have been distorted by myths. You may have heard some of these myths stated as "truths." In part, this may be because we tend to focus on the problems and negative aspects of aging. Most myths have some basis in fact, but generally they reflect the exceptions rather than the rules.

Pro 11:25 - 31- Be generous, and you will be prosperous. Help others, and you will be helped. Those who are good are rewarded here on earth, so you can be sure that wicked and sinful people will be punished.

Chaplain Fellowship Ministries is a Faith Based 501(c) 3 IRS Tax Exempt Public Charity, legally Incorporated as a Non-Profit Corporation with Chaplains, Pastors, Priest and Ministers working worldwide.

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Here are some common myths about aging, with accompanying explanations of the realities.

Myth: Older people are more rigid and resistant to change.

Reality: Aging does not make a person rigid, inflexible, and resistant to change. Older people may seem more rigid because they grew up during a more conservative time than today's younger adults. However, the ability to adapt and be flexible has more to do with lifelong personality than with age. Later life actually is a time of many changes--death of spouse, family, and friends; retirement; loss of health and mobility; and reduced income--requiring profound adjustment. Most older people adapt well to these changes, and many develop new interests and take on new directions in life.

Myth: Personality changes with age.

Reality: Personality patterns tend to persist throughout life. You are what you are for as long as you live unless you make a conscious effort to change, or a medical condition--such as Alzheimer's disease or a stroke--affects your personality. In general, old age merely continues what the earlier years have launched. If you have been an easygoing, fun-loving person, you likely will continue to be the same when you are older. On the other hand, if you always have been impatient and critical, you probably will remain so.

Myth: Aging brings with it a decline in intellectual abilities and learning.

Reality: Some loss of brain cells does occur with aging, but it has negligible effect on the brain's ability to function. Barring major illness, you can expect your mind to be alert and active well past age 80. When intellectual functioning does decline, it usually is a result of health problems and often occurs shortly before death. Such sudden deterioration in intellectual functioning has been called *terminal drop*.

Many intellectual functions such as reasoning, vocabulary, and special skills in which you remain actively involved often improve with age. If you are healthy and active, you can expect *crystallized intelligence*--the ability to use accumulated knowledge to solve problems and make decisions--to increase steadily throughout life. You may experience some decline in *fluid intelligence*, which is

related to speed and similar functions. However, these changes have minimal effect on learning and everyday functioning.

The adage "You can't teach an old dog new tricks" is true of neither old dogs nor human beings. You can learn throughout life. In later life, we tend to learn more slowly than we did when we were younger, but we can learn just as well. Like other parts of your body, your brain's ability to function remains best when it is used regularly.

Myth: Memory loss is inevitable in later life.

Reality: Many people worry that growing old means losing the ability to remember, think, or reason. Memory loss is *not* normal in later life; however, some change in the ability to recall recent information is common. This may be because "old memories" stored in the brain interfere with the recall of new information. Think of your brain as a library in which you are looking for a particular book. If it is a young library with only a few books, the one you seek will be easy to find. If it is an older library full of thousands of books, finding a particular book will take longer. But the book is still there if you take the time to look for it. Patience may be required to locate a certain book in a "large and full library."

A significant impairment in memory generally is the result of disease or brain injury. Alzheimer's disease and multi-infarct dementia (a series of small strokes) are the major causes of serious memory loss. Long-term alcohol abuse may cause irreversible brain damage. However, some damage may be halted or reversed by stopping drinking and getting treatment.

Many common causes of memory loss are reversible. These include:

- Minor head injury
- Fluid imbalance
- High fever
- Poor nutrition
- Adverse drug reactions
- Depression

Anxiety, fatigue, stress, and grief also can affect memory temporarily. These factors can interfere with taking in, retaining, or retrieving information. Depression, for example, can reduce concentration so that information is not apprehended in the first place.

People who feel they are having memory problems should see their doctor. If there is no medical basis for the problems, memory can be enhanced with active use and memory improvement techniques.

Myth: Older people have no interest in, and are incapable of, sexual activity.

Reality: Sexual needs, desires, and functioning do not change abruptly with age. If you are in reasonably good health, you can have an active and satisfying sexual life in the later years. The greatest limits to sexual activity in later life are lack of a sexual partner, misinformation, and negative stereotypes. Too often, sexual activity for older adults is seen as unnecessary, impossible, or just "not nice."

Human sexual response may be slowed by the aging process, but it certainly is not ended. Poor health, medications, and psychological factors such as anxiety, depression, and fear of failure are more important contributors to a decline in sexual activity than is aging. If you believe your sexual life is being affected by such factors, seek a thorough medical evaluation.

There is no age limit on the need for affection, for touch, to love and be loved, and to be recognized as a sexual person. For people who have never received pleasure from sexual activity, age may be used as an excuse for giving up sex. For most people who have enjoyed an active sexual life, the desire and capacity for sexual expression continues.

Myth: Urinary incontinence is to be expected in later life.

Reality: Urinary incontinence is neither normal nor inevitable in later life. However, it is more common among adults 65 years of age and older. Women, in particular, are affected. Urinary incontinence affects 15% or more of older adults who live at home and up to 60% of people living in nursing homes. It is one of the most common reasons for nursing home admission.

Eighty percent of urinary incontinence cases can be cured or significantly improved, yet half the people affected never seek medical help. Because of the stigma associated with incontinence, people who lose bladder control often restrict outings and social activities. They fear they will "have an accident" or that others will smell the odor of urine. A vicious cycle can develop: Incontinence leads to isolation and inactivity, which may lead to depression, which further increases isolation. Incontinence can be effectively managed, so seek medical help!

Myth: Older people require less sleep.

Reality: The quality of sleep may decline in later life, but not total sleep time. As people age, sleep tends to become more fragmented with more frequent night awakenings, even in healthy, active, older adults. Some people find that brief naps or rest periods, regular exercise, good diet, good mental health, and limiting alcohol intake promote healthful sleeping patterns.

Myth: Older workers are not as effective as younger workers.

Reality: On most measures of effectiveness, employed older persons generally perform as well as--and sometimes better than--younger employees. Some studies do show a decline in performance with age when physical strength or speed are important. Older workers, however, are more dependable, have lower turnover rates, have fewer absences and accidents, show better judgment, and are as productive as younger workers.

Myth: Older people are fearful of death.

Reality: Many people believe that because older people are closer to death, they are more fearful of death. In general, older people tend to approach dying in much the same way as they have approached life. The majority are not afraid of or preoccupied with death. Only about 10% of older people express a fear of death. For many older people, their greatest fears are a prolonged illness and loss of mental functioning.

Death is a reality for older people as friends and family members die. It is normal and healthy to face this reality and talk about it at times. It's important not to confuse talking more about death with being fearful.

Myth: People become more religious as they age.

Reality: People do not become more religious as they age. Religious beliefs and practices are established early in life and tend to remain fairly stable into later life. When compared with the present younger generation, today's older generation were more religious in their youth and have continued the religious path established early in life. Even among today's older population, there is great diversity in religious beliefs and practices, ranging from no belief in religion to active dedication to a major religion such as Christianity, Judaism, Buddhism, or Islam.

Myth: It's normal for an older person to be depressed.

Reality: Depression is not normal in later life, nor is it more common in later life than at other stages of life. One study of depression among the elderly found that 19% suffered from mild dysphoria or sad mood, and 8% were more severely depressed. Persons who are in long-term care facilities, who suffer from severe medical illnesses, or who are extremely isolated experience a significantly higher rate of severe depression.

Depression among older people often is overlooked or misdiagnosed. Sometimes the symptoms are not typically associated with depression. For example, some older people who are depressed will have impaired concentration

and memory, and as a result may appear more confused than depressed. Physical illness can mask depression, and depression can mimic physical illness.

Myth: Therapy for depression or other psychological problems doesn't help older people.

Reality: Therapy can help older people greatly. There is no relationship between age and the success of therapy. However, the earlier treatment is sought, regardless of age, the more successful it generally is. The longer a problem is neglected, the more complex it becomes, the more likely other problems will develop, and the more difficult it is to treat.

Too often, the older person does not seek help until a problem is well advanced and more resistant to treatment. Sometimes emotional changes in the older person are wrongly attributed to "old age" or the worsening of an existing medical problem, and treatment is not sought. Or the signs of depression simply may not be recognized. It is important to remember that there is effective help for most emotional problems, including depression.

Myth: Drug misuse and abuse are not problems among the elderly.

Reality: Studies show that 50% of older people fail to take their medications as prescribed. Also, many medications are not as well tolerated by the elderly, and changes occur in the body that may change the absorption, metabolism, distribution, and excretion of drugs.

Drug misuse is important because of its effects on the health and brain functioning of older adults. An older person who takes multiple medications, perhaps several times a day for different health problems, is at greater risk for problems with medication. Common types of drug misuse among older adults are:

- Overuse--taking more than a prescribed amount of a medication or taking medications that are not needed.
- Underuse--taking less than the prescribed amount of medication or not getting a prescription filled or refilled.
- Erratic use--failing to follow directions, missing doses, trying to make up for a missed dose by doubling the next dose, or not remembering when or how to take medication.
- Contraindicated use--the doctor's prescribing an inappropriate medication.

Each of these types of drug misuse can be prevented by doctors and older patients working together. Patients always must be truthful about how they use or don't use their medications and should expect their doctors to work with them to make medications manageable.

Alcohol is the most commonly abused drug by people of all ages in our society. Researchers estimate that as much as 10% of the older population has a problem with alcohol. However, alcohol abuse in later life often is overlooked. The signs of alcohol abuse may be attributed wrongly to "old age," physical illness, or dementia.

Alcohol acts differently in older adults. Older persons cannot "clear" alcohol as fast--they become intoxicated more quickly and their blood alcohol remains higher longer.

Myth: There's not much an older person can do if he or she has a chronic disease, except to take medication.

Reality: Lifestyle is very important in the development and treatment of chronic illness. For example, stopping smoking--even when older--can reduce the risk of cancer and heart disease. Exercise can strengthen the heart and lungs, increase muscle tone and bone mass, and lower blood pressure. A person with a significant chronic illness should be as active as possible and follow medical recommendations carefully. Attitude also is important in managing a chronic disease.

Myth: Most older people are lonely and want to live with their children.

Reality: Most older people do not report feeling lonely. Some researchers have found that people over age 65 are less likely to feel lonely than people under 25. However, limited hearing, vision, and mobility do result in isolation and loneliness for some older people.

As long as older people can manage independently, they prefer to live in households separate from their children. "Intimacy at a distance" is preferred both by older people and by their adult children.

Myth: Older people often are abandoned by their families.

Reality: For almost all older persons, families are important. When family is not a part of an older person's life, there usually have been long-standing relationship problems and estrangement. The family still is the number one provider of support and caregiving to older persons, providing at least 80% of the needed support. Nowadays, families give more care for longer periods than families did in "the good old days."

Even when bedridden or homebound, older persons are twice as likely to be cared for at home than in an institution, with care being provided by a spouse, adult child, or other relative. Extended family members--for example, a niece, nephew, or grandchild--often help when an older person does not have a spouse

or adult children. Brothers and sisters often play an important role in the lives of older persons who are widowed or have never married.

Contact is frequent between most older persons and their adult children. Both generations give and receive. The most comfortable relationships exist when both generations love each other and respect one another's rights.

Myth: Families use nursing homes as a "dumping ground" for frail older family members.

Reality: Most people in care facilities are greatly impaired and need comprehensive care. Older people who don't have children and live alone are the most vulnerable to nursing home placement. Approximately half of all nursing home residents are single women or widows without close family.

Most families do not suddenly "dump" and abandon their older family members in care facilities. The reality is that most families use nursing homes as "the last resort," only after they have exhausted other alternatives. Families often endure tremendous hardship and stress to maintain older family members in the community. The decision to place a frail elderly relative in a nursing home is traumatic and painful for most families. Feelings of guilt, fear, and failure are common, even when objective evidence indicates that a nursing home is the best choice for everyone.

Myth: Most older people are in nursing homes.

Reality: Only about 5%--1 in 20--of people over age 65 are in nursing homes or other institutions. However, the percentage increases with age. About 22% of persons over age 80 reside in care facilities. On the average, elderly persons in care facilities are older than elderly persons living in the community.

It used to be that when people entered a nursing home, they didn't expect to leave. Today, many people enter a nursing home to recover from an illness or surgery, or for rehabilitation, and then they return home. This is particularly common now that hospital stays have been limited by Medicare and private insurance payers.

Myth: Medicare pays for most long-term nursing home and in-home care costs.

Reality: Medicare's coverage for nursing home care is minimal. It pays for less than 2% of all nursing home costs. Medicare has limits on the amount of time and circumstances under which it pays for nursing home and in-home care. Medicare will cover only the costs of care that is "skilled nursing" and provided in a Medicare-approved facility. Most older people in nursing homes require what is called "custodial care," which Medicare does not cover.

Older adults and their families pay over 50% of all nursing home care costs. Medicaid, a government program for low-income persons, pays over 40% of all nursing home care costs. Because Medicare and Medicaid regulations change from time to time, it is important to learn about how these funding sources can help with individual long-term care needs. You can get help understanding Medicare and Medicaid from your state or county aging services, nursing home or other long-term care facility administrators, or directly from the Medicare or Medicaid administrative agencies in your state.

Myth: Poverty no longer exists among the elderly.

Reality: Although the percentage of older people living in poverty has declined steadily over the past few decades, the elderly continue to have the highest poverty rate of any adult age group. According to the 1990 Census Bureau Report, 12.2% of the older population are living in poverty. In addition, almost 40% of the elderly are considered economically vulnerable because their incomes are only moderately above the federal poverty line.

Poverty is particularly acute among older widowed women, persons 85 and older, and elderly members of minority groups. The greatest threat to the economic security of older adults is out-of-pocket costs for health care.

Conclusion

People over 65 are a diverse group and no one description can tell you what they are like. The cumulative effect of years of individual experiences makes people more different, rather than more alike, in later life.

Myths can be self fulfilling, if you believe them. For example, if you expect to be sick and alone when you are old, you probably will be. Your attitudes toward aging will affect how you age and how you respond to older people. A Yiddish proverb states, "Old age to the unlearned is winter; to the learned, it is harvest time."

The facts paint a bright picture of aging and older people. Older adults can be active, alert, interested, and interesting. In later life, you will have changes to make and some difficult situations to face, but usually these don't have to limit you severely.

The Basics

Major Types of Elder Abuse

Physical Abuse

Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.

Signs and symptoms of physical abuse include but are not limited to:

- bruises, black eyes, welts, lacerations, and rope marks;
- bone fractures, broken bones, and skull fractures;
- open wounds, cuts, punctures, untreated injuries in various stages of healing;
- sprains, dislocations, and internal injuries/bleeding;
- broken eyeglasses/frames, physical signs of being subjected to punishment, and signs of being restrained;
- laboratory findings of medication overdose or under utilization of prescribed drugs;
- an elder's report of being hit, slapped, kicked, or mistreated;
- an elder's sudden change in behavior; and
- the caregiver's refusal to allow visitors to see an elder alone.



Sexual Abuse

Sexual abuse is defined as non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

Signs and symptoms of sexual abuse include but are not limited to:

- bruises around the breasts or genital area;
- unexplained venereal disease or genital infections;

- unexplained vaginal or anal bleeding;
 - torn, stained, or bloody underclothing; and
 - an elder's report of being sexually assaulted or raped.
-

Emotional or Psychological Abuse

Emotional or psychological abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation are examples of emotional/psychological abuse.

Signs and symptoms of emotional/psychological abuse include but are not limited to:

- being emotionally upset or agitated;
- being extremely withdrawn and non communicative or non responsive;
- unusual behavior usually attributed to dementia (e.g., sucking, biting, rocking); and
- an elder's report of being verbally or emotionally mistreated.

Neglect

Neglect is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care.

Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.

Signs and symptoms of neglect include but are not limited to:

- dehydration, malnutrition, untreated bed sores, and poor personal hygiene;
- unattended or untreated health problems;
- hazardous or unsafe living condition/arrangements (e.g., improper wiring, no heat, or no running water);



- unsanitary and unclean living conditions (e.g. dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing); and
 - an elder's report of being mistreated.
-

Abandonment

Abandonment is defined as the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Signs and symptoms of abandonment include but are not limited to:

- the desertion of an elder at a hospital, a nursing facility, or other similar institution;
 - the desertion of an elder at a shopping center or other public location; and
 - an elder's own report of being abandoned.
-

Financial or Material Exploitation

Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney.

Signs and symptoms of financial or material exploitation include but are not limited to:

- sudden changes in bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying the elder;
- the inclusion of additional names on an elder's bank signature card;
- unauthorized withdrawal of the elder's funds using the elder's ATM card;
- abrupt changes in a will or other financial documents;
- unexplained disappearance of funds or valuable possessions;
- substandard care being provided or bills unpaid despite the availability of adequate financial resources;
- discovery of an elder's signature being forged for financial transactions or for the titles of his/her possessions;
- sudden appearance of previously uninvolved relatives claiming their rights to an elder's affairs and possessions;

- unexplained sudden transfer of assets to a family member or someone outside the family;
 - the provision of services that are not necessary; and
 - an elder's report of financial exploitation.
-

Self-neglect

Self-neglect is characterized as the behavior of an elderly person that threatens his/her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice.

Signs and symptoms of self-neglect include but are not limited to:

- dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene;
- hazardous or unsafe living conditions/arrangements (e.g., improper wiring, no indoor plumbing, no heat, no running water);
- unsanitary or unclean living quarters (e.g., animal/insect infestation, no functioning toilet, fecal/urine smell);
- inappropriate and/or inadequate clothing, lack of the necessary medical aids (e.g., eyeglasses, hearing aids, dentures); and
- grossly inadequate housing or homelessness.