Social Work Services to Patients in the Jewish Institution*

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There is no entity as sectarian medicine, but there is a set of institutional values which have motivated the existence of Jewish institutions at some level. This needs to be identified and made explicit. If it were not true there would be no reason for the existence of Jewish institutions.

The Context of Jewish Social Work

What's Jewish about social work services in the Jewish institution? What's Jewish about a Jewish hospital? As long as I can recall the Proceedings of the National Conference of Jewish Communal Service, and if my memory serves it is more than thirty years now, this question has continually been posed. And we have tried to answer via a variety of methods: buzz sessions, general sessions, specialized group sessions, or just plain bull sessions. I am not convinced that we have arrived at a satisfactory answer because this year in one form or other the same question has been raised.

Why is this year different from any other year? Perhaps it's not. On the other hand, the theme of this year's meeting is "Furthering Jewish Life in the Free Society after Two Hundred Years." If we are to examine the Jewish institutions as they developed during these 200 years we would have to conclude that not only have some profound changes taken place in Jewish communal life, but also, the quality of life in the country, as a whole, has been drastically altered. In the Jewish community the nature of the Jewish hospital and the reasons for existence have changed markedly since their beginnings.

An excellent article by Dr. Cecil Sheps describes this very well. The development of Jewish hospitals was in response to three needs. (1) The need and obligation of the Jewish community to look after the Jewish emigrants and the Jewish poor who required medical care. (2) The need of Jews with distinctive religious and ethnic backgrounds who required medical care which could not be met in Jewish institutions and (3) The need for Jewish physicians to find employment in non-Jewish hospitals.[1]

Social work services in Jewish health care institutions have grown as well. But this is not peculiar to Jewish hospitals since social work services and the availability of these services have also expanded in many health care agencies. One significant statistic is that the percentage of hospitals employing social workers throughout the country is 60 per cent compared to approximately 35 per cent five years ago. There are 7,000 hospitals of which 54 are under Jewish auspices. Another interesting statistic is that one out of every three professional social workers employed in this country is now working in a health-care setting.

Differences and Similarities

Are social work services in the Jewish institution no different from social work services in public or non-sectarian agencies? There are indeed similarities, but there are also significant differences.

To elaborate requires definition of some parameters. The Jewish community supports Jewish health agencies largely through Federations, (though the dollar amount is small as compared to support for other Jewish communal institutions) and through Jewish individuals and families who give large sums of money on their own. This community, which supports the Jewish health-care agencies, includes an identification with a range of secular and religious groups with varying approaches and solutions to Jewish communal problems. The major funding does not come from sectarian auspices, but from a variety of government and so-called third party sources.

Another factor which delineates the provision of social work service in Jewish institutions is the influence of the Jewish family and Jewish culture. A family can identify itself either secularly or religiously to be Jewish, by virtue of religion, Jewish nationalism, or through Jewish cultural identification. Social workers who come from cultural or religious Jewish backgrounds also identify themselves in similar ways.

Thirdly, the Jewish hospital today is identified within the context of Jewish communal service. Linkages with social agencies within that network can and have been developed for joint planning regarding criteria for admission, discharge, referral and provision of social work services within that framework. We have not reached the millennium in the realm of cooperation between Jewish agencies and medical settings. Agencies within the Jewish communal network can work more closely together and do more than they have done up to now. There are also, in some instances, highly motivated and excellent relationships that exist between Federation agencies and those outside of the network. But there is a natural gravitation of the agencies within the communal network to relate more easily to each other, precisely because of the unique cultural and historical background, common funding and interlocking boards.

The relationship that exists within the Jewish Federation, although not always what it should be, is nevertheless different because of that context. At times the Jewish agencies are more critical of one another than they are of the secular agencies that they work with. They tend even to be paranoid of each other, but if one can still afford to be psychoanalytical in this day, we can conclude that it is safer to be overtly hostile with those we feel closest to. Another important influence which affects the delivery of social work services in a Jewish institution is the need to demonstrate a significance and rationale for being Jewish. We place a premium on pioneering and innovating programs. The outstanding institutions in the Jewish communal field, both in family work and in medical care, and the social work departments of these Jewish health institutions, as well as in the Homes of the Aged, have all pioneered and are recognized as leaders in developing programs. The need to improve ourselves or to demonstrate that we have reason for being has led to a great spirit of competition and aggressiveness in seeking new paths in service delivery. The new way has often turned out to be better than the old. Jewish agencies cannot claim a monopoly for innovation nor is it accurate that non-Jewish communal institutions do not have programs as good as those which exist within Federation. On the contrary it seems to me we are losing ground in some areas. But whatever the motivating factor it is strong enough to push Jewish communal services into attempting innovative patterns. From this point of view there is ample evidence that surely we remain in the forefront of all communal institutions.

Tradition and Health Care

What is there about the provision of health and welfare services in Jewish institutions which contributes to this spirit? We have to look toward our tradition and to the culture of Jewish institutions particularly as it is affected by the history of Jewish medicine.

Medicine was the avenue through which Jewish men of letters and the rabbinate sought to gain visibility to the world outside of Judaism. Many of our most noted rabbis were indeed physicians as well. It is estimated that half of the prominent rabbis, Jewish philosophers, and Jewish poets were physicians. This alliance between medicine and the influential Jews was for the express purpose of gaining access to the non-Jewish world and this has affected the attitude of the Jewish community towards health and medicine.

A number of principles of Jewish law as

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[1] Cecil Sheps, "The Houses of Health," *Moment,* December 1975, pp. 54-58.

applied to health and medicine have profound significance for social work practice in the health institutions. Medicine as defined by Jewish law is prophylactic in nature. This concept of prevention, perhaps stemming historically from the very early days of Jewish history when the need to prevent illness was far more important than that of treatment, has been defined and described more extensively by Rabbi Elie Munk.[2] Many of us now who are involved in the delivery of health-care services have come to the same realization. Despite our great modern health technology, the need for prevention is economically far sounder than that of developing treatment programs. The implication for social workers in health agencies under Jewish auspices is that there is every reason for Jewish social workers to be much more heavily involved in social action which bears on the preventative aspects of health care. However, social work in health settings should and cannot afford to forego seeking competence and improvement in practice skills. On the contrary as Herman Stein so well points out, system change by social workers can only be followed through if we have established ourselves as experts in system maintenance.[3]

Jewish law has had another profound effect on health services under Jewish auspices. Jewish law defines the concept of unity in medicine through identifying religion, morality and hygiene as significant components of prevention and treatment in medicine. The theory of multiple causation which almost all health workers recognize today springs from this notion. A parallel concept is psychosomatic medicine, the body and the mind compose an inseparable whole. Thus it is logical to expect that health care institutions would be particularly interested in psychosocial genesis of prevention, treatment and rehabilitation, and social work departments in health care institutions of Federation should be profoundly interested in making available and accessible such services to all segments of the Jewish community.

Another significant aspect of Jewish law applied to medicine is the recognition of the human factor in the ethical code which if it can be expressed in one word is tolerance. In Jewish law the sanctity of life and health has precedence over all religious sanctions. Rabbis, therefore, in giving us this law recognize the significance of life above all else and the importance of maintaining and sustaining life even at the expense of religious practice. It is for these reasons that medicine in many ways has been, and probably still is, the favorite profession of the rabbinate.

In spite of this favoritism the present health system in which Jewish health-care institutions find themselves has developed a value system which at some point is at variance with that posed by those who wish to adhere strictly to Jewish law. The present health setting is based on concepts of scientism, rationality, and authority. The clinical picture is assessed as objective and impersonal, often to the extent of becoming dehumanizing. This has led to the hierarchy in health care settings with the physician on top of the scale and the patient on the bottom (consumer). The patient is almost always wrong in the health industry. This is changing to some small extent, but only because of government regulations. It is not a willing nor often agreeable change for health professionals but if sustained it will also influence social work services provided in these Jewish institutions and perhaps facilitate a return to the Jewish concept of the sanctity and centrality of the individual. A factor that needs to be considered in health-care institutions is that the staff of Jewish institutions, particularly hospitals, is principally made up of a complement in which the more highly trained staff, the professionals, are predominantly Jewish and those in the supporting services such as maintenance, housekeeping, and dietary staff are not. This is in contrast to the predominantly non-Jewish populations served by many of the Jewish hospitals. This

[2] Elie Munk, "Foreword" in Immaneul Jakobovits, *Jewish Meidcal Ethics*. New York: Bloch Publishing Co., 1959, pp. XIX-XXVIII.

[3] Herman D. Stein, "Social Work's Developmental and Change Functions: Their Roots in Practice," *Social Service Review*, 1976, pp. 1-10.

poses problems for many health-care institutions as Federation knows only too well. The social worker and the other well trained professionals in the Jewish health-care system principally from the middle-class find themselves caught between traditionalism, if they have been exposed to any degree of identification with a segment of Jewish culture, and the rational, scientific aura of medicine which although under attack nevertheless predominates in the Jewish institution.

The Jewish social worker (and many of the social workers in the large Jewish hospitals are Jewish and identify themselves in some way as such) does not have a fundamentalist background. Many attack fundamentalism and tend for psychological or other reasons to be non-religious. They may also become associated with humanist groups which are neither Jewish nor non-Jewish, but profess a secular base.

Dilemmas of the Jewish Social Worker

The social worker in the Jewish agency is faced with several dilemmas in providing social work services. The tools that the social worker has, in contrast with other disciplines with whom he works in the health field, is not external to himself. The physician has a stethoscope. The psychologist, his tests or machines which do cognitive and perceptual testing, the rabbi has the Book, the Torah, the Bible. The social worker has only himself. And this self has been oriented and taught through two years of graduate work that one of the most profound tools he has to work with is a value system. What is this value system then that might bring the Jewish social worker in the health-care institution into possible conflict with the attempt to reconcile Jewish law and social work teachings?

A social work principle about which there has been misunderstanding, misinterpretation, and a great deal of controversy is the concept of self-determination. How much self-determination is possible in reality? Social workers are taught to respect that everyone has the right to determine for oneself what one can do. This is a libertarian point of view, and translated into working with clients is often seen as meeting the client at his level and working with the problems that the client presents. This concept comes under attack in an authoritarian setting, particularly when economic costs, religious law, and other disciplines are determining not only what is best for the patient but for the institution as well. Sometimes these factors and social work principles are not congruent.

Another conflict is the right of the individual versus the responsibility of the non-Jewish and Jewish communities. The middle and upper economic classes refuse to accept that the indigent may require more help and are demanding if necessary that the poor and the handicapped shift for themselves. Rights of the individual are subordinate to the rights of the community and to those of the Jewish institutions. The right of an individual to receive service based on his needs cannot often be met. This poses a problem for a social worker particularly a social worker in a Jewish hospital who wants to provide service out of a Jewish ethos and commitment.

Another question which needs resolution is "whose life do we serve?" This issue is expressed in the controversy over abortion and family planning which affect the nature of social work services in the Jewish hospitals. Hospitals under Jewish auspices have tended to be more liberal and tolerant in the provision of social work in these areas, but from time to time, this issue needs to be examined in the light of the opposition to this concept by the more Orthodox community.

Another area has to do with professional confidence. In an authoritarian setting such as a health setting where the social work services are not seen as primary, making available such services does not get top priority, although the history of the Jewish community would indicate that prevention and psychosocial aspects of health-care are as important as the treatment phase. The Jewish hospital exists for a variety of reasons and there is a need for it, but whether the use of the money, energy and highly skilled manpower should be mobilized to curb illness instead of using these hospitals

as first-aid stations is another matter. If indeed prevention is as important as treatment then social work services could take on deeper and more significant functions as has occurred in Great Britain, India and the Scandinavian countries.

While the Jewish social worker should not be made to carry the burden as the culture bearer of Judaism, the dilemmas faced by the social worker in the Jewish hospital are great. The orientation of the Jewish social worker first as a Jew and secondly as a social worker can bring him into conflict with some of the prevailing concepts in health-care institutions particularly those that are Jewish. But the social worker can also serve as the link between the Jewish patient and the support system of the Jewish community. In this way the social worker clearly identifies a part of the commitment to serve the Jewish patient.

The problems of the Jewish social workers are also his strengths. There are differences, tensions and struggles within the Jewish institution but this does not mean that the social work profession cannot make strides. The growth of social work services in Jewish health-care institutions has shown that despite differences and difficulties the need and the demonstrated effectiveness of these services have convinced many that the profession has a very substantial and growing place in the provision of health-care services for patients, particularly Jewish patients.

The problems of the social worker in the Jewish hospital are important and we should recognize them. As a group of Jewish social workers we tend to pay lip service to Jewish communal and Jewish familial systems, i.e. a non-ethic psychotherapy. As a middle-class conforming group we tend to observe with disdain, either consciously or unconsciously, deviant cultures. The psychotherapeutically oriented approach that many social workers, not only Jewish, are identified with, places emphasis on illness and pathology. Emphasis on psychotherapy in one form or another as the significant social work interventive technique develops "tunnel vision". We are more involved with interpersonal and psychological problems and are only aware of the peripheral aspects of the social problem. This may be because the former are more interesting and tend to fit our theories more aptly than some of the other more mundane problems that exist. It may be for this reason too that Jewish social workers as well as others failed to recognize the existence of large numbers of Jewish poor in New York City. We were more interested in doing "psychotherapy" than "social therapy". We have not viewed individual and family "Jewish" problems socially and sought communal solutions.

What this suggests to social workers in Jewish health care is that psycho-social data is important and we must also work to mobilize the resources of the institution and of the Federation and Jewish communal networks to provide services that patients require.

Special Relationship of Social Work Services

How does this work itself out in the Jewish institution: What are some of the practical things that Social Work Departments in Jewish health-agencies need to do?

Basically the function of social work services in the Jewish institution is not descriptively different from similar services identified as such in other health-delivery systems. Assuming, however, that there is an identification of the institution on some level with Jewish cultural or religious values, one must suppose that there is an equal commitment on the part of the Jewish social work service to that agency for the service to work closely and effectively with other disciplines within the Jewish institution and in the community. Some of these commitments may pose value conflicts for some social work staff, but these dilemmas are no different from the crisis and the conflicts faced by social workers working in non-Jewish institutions. But the special relationship of the Jewish institution to the community should mean that there must be a reach-out program to service at least the Jewish community for it to maintain its identity. There surely must be a commitment today of all Jewish institutions to the Jewish aged. All aged require help, but Jewish hospitals identifying themselves as Jewish, must mount outreach programs which will specifically encompass the Jewish aged. There is also a special responsibility for the Jewish institution to be involved in community problems involving the Jewish aged because they do represent a neglected, alienated, and fearful group. The social workers in Jewish institutions have a special role to play. It is their responsibility at the time of admission of patients to be able to identify those high risks populations which would include the Jewish aged who are living alone or have chronic illness and require social services. There are other similar groups deserving primary attention becuase of their social problems generated by those social and economic conditions.

The next task for the social worker is to provide the services to meet and help mitigate if not resolve the problems, i.e. the discharge of the aged to special kinds of nursing homes that will meet requirements of the Jewish aged. Some Jewish patients wish to adhere strictly to religious and cultural traditions and social workers in Jewish institutions need to develop special kinds of programs to meet these needs. At the Long Island Jewish-Hillside Medical Center special programs have been developed with the Jewish Institute for Geriatric Care, located on the LIJ-HMC campus, socialization programs with the Samuel Field Y and the use of volunteers to follow patients in nursing homes after placement.

The treatment of patients in the hospital also poses several problems. There is no entity as sectarian medicine, but there is a set of institutional values which have motivated the existence of Jewish institutions at some level. This needs to be identified and made explicit. If it were not true there would be no reason for the existence of Jewish institutions. The values are or should be reflected in some way in the delivery of medical and social services. Social workers in Jewish health-agencies should know that some Jewish patients may request special diets, or that some Jewish patients wish religious services, or that Jewish cultural values usually are reflected in some phase of Jewish family life.

Social work services should also be made available to families of patients who are suffering from "Jewish-related" medical phenomena such as Tay-Sachs, Neiman-Picks, and hymolytic anemia. There are still many who are suffering from problems brought on by the holocaust, psychological as well as physical. And there are those who are suffering from more recent waves of persecution such as the emigres from the Soviet Union and the North African countries. The Jewish poor require special services which Jewish health-care agencies may be able to provide from a particular vantage point of view.

Because it is related to and is within a Federation network of related institutions the Jewish institution can offer a special kind of service as well as meaning to the patient who identifies himself on some level as being Jewish.

As an example, family agencies can play a crucial part in aftercare planning. This is particularly relevant today when governmental funding for institutional care has been curtailed, agencies in the community will need to pick up on some of the services. Closer liaison between the Jewish family agencies and the Jewish hospital can result in less duplication of services. Methods can be found to plan and work together to eliminate program duplication and to make better use of staff on all levels. Training and research programs, and demonstration projects can be developed jointly particularly by agencies within the same or close geographic proximity. Long Island Jewish-Hillside Medical Center is working very closely with the Jewish Institute of Geriatric Care in the student training program, in the staff development program and transferring of patients between these institutions. Staff members of JIGC participate in seminars for social work staff at the LIJ-HMC Social Work Department, and by the same token social workers from the LIJ-HMC will be attending seminars given at the JIGC. There is interchange of staff for teaching purposes.

The student training center includes the JIGC and the Samuel Field YMHA. One staff member is responsible for directing this program and is funded jointly by the agencies involved.

These special relationships do exist and there are many other examples because there is a level of identification with Jewish values that directs these institutions toward each other. There may be struggles over turf and conflict over who shall be administering or directing a specific program. But it is worth the struggle if we can bring together scarce resources—funds, skilled manpower and ethnic commitment—to improve patient care.

Conjoint Family Treatment as an Adjunct to Group Treatment of Young Jewish Women*

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Confronted with rapidly changing societal values, young women today are seeking redefinition of themselves in their female role. The impact of women's liberation movement, with its greater freedom of choices for social and sexual behavior, creates conflict between the values of their parents and those of their peers.

New approaches in social work counselling concerned with problems in family communication and interpersonal understanding are again being studied. The authors are experimenting with a combination of treatment modalities to further intergenerational communication.

This presentation is from current practice. It describes various treatment modalities used with young women, between the ages of 17 and 20, who are struggling with consolidation of their identities and individuation and emotional separation from their parents.

The Long Island community in Nassau and Suffolk Counties, which JCSLI services, is a middle-class culture. Families come to a *Jewish* agency because of the special meaning it has to them, expecting to be understood, and relying on a common bond of identity with the treating social workers. The agency has a commitment to strengthen Jewish family life through a process of aiding individuals to solve their personal and intrapsychic problems.

Family treatment is shared by the two social workers using individual sessions, separate peer groups for parents and for daughters, and conjoint family sessions. The uniqueness of this treatment approach lies in the regularly scheduled, structured, conjoint family session held with both workers participating in the family system and acting as an enabler for her own client. The conjoint sessions are used for those in group as well as those in individual treatment.

The parents in these groups range in age between 45 and 60, with two or three children in late adolescence and young adulthood. The fathers are small business men or professionals; some of the mothers are similarly employed while others are housewives. They have raised their children in an atmosphere of permissiveness while encouraging independent behavior and gratification of material needs. Advanced education and increased socioeconomic status are goals for themselves and their children. The parents maintain a strong sense of their Jewish heritage and expect the same of their children. They are concerned and confused about the life style their daughters have chosen.

Confronted with rapidly changing societal values, young women today are seeking redefinition of themselves in their female role. The women's liberation movement, with its greater freedom of choices for social and sexual behavior, creates conflict between the values of their parents and those of their peers. The nightly bar and disco is the scene of social activity for the young women we see. This setting has become the social center where they can experiment with new identities and make their assertions toward emotional independ-

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