

# A COMMUNITY OF CARING

## *Patients in a Rehabilitation Unit Experience Holistic Healing through a Spiritual Support Group*

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**H**ow can a chaplain effectively foster holistic healing in a hospital or long-term care center? One proven way is to form a Community of Caring, a program that offers patients a time, place, and ambience conducive to sharing their pain and fears in ways that will encourage them to value the sacredness of the moment and to fully use the hours and days of recovery to deepen their relationships with self, others, and a loving God.

In the late 1980s, when I was a chaplain on the physical rehabilitation unit at Mercy Hospital, Chicago, I began a Community of Caring, a concept that could easily be adapted in other units in the hospital. The need to form a Community of Caring was brought home to me by a patient's rebuke. "How come you aren't helping us patients in the rehabilitation unit pray more?" questioned Goldie. The stroke that had incapacitated her limbs had in no way affected her mind or tongue. "The chaplain we had before you came, she used to cheer us up and got us togeth-

er to pray that we'd get better and get out of here quick." Her eyes challenged me; her frown implied that as the new chaplain on the unit, I had neglected my most important functions: "cheering up" and "praying with."

My strong commitment to holistic healing prompted my quick retort: "On the rehab unit, I'd like all of us, patients and staff, to think less about disabilities and discharge from the unit and, instead, to find meaning and value in the rejuvenative therapies, discovering how we can help each other make the best use of the time spent here." Ignoring Goldie's "Humph," I continued: "This morning I saw you walking between the parallel bars, doing your best to stand straight; you walked 12 feet, pivoted, returned, sat in your wheelchair correctly. Working like that in therapy can be a prayer, don't you agree?" Goldie glared her response: "That weren't no prayer. It was work, darn hard work."

As she wheeled herself away, I thought to myself, "And it will be 'darn' hard work to convince her—and many other patients—that healing

**Summary** Empowered by empathic knowledge of the pain and suffering endured by patients, a pastoral care giver can foster holistic healing, integrating a spiritual dimension into the lives of responsive individuals by helping them form a circle of love, a Community of Caring.

A Community of Caring can be effective in many specialized hospital units or long-term care centers. In a hospital physical rehabilitation unit, for example, a chaplain successfully provided a time, place, and ambience where patients could share their deepest feelings, thoughts, and concerns and learn together techniques of coping.

This Community of Caring helped patients overcome feelings of inadequacy and low self-esteem,

encouraged self-acceptance despite physical losses, and stimulated new concepts of spirituality, notably the importance and the sacredness of the present time spent in recuperation. Participants in the Community of Caring discussed ideas such as the concept that all activity, even mundane rejuvenative therapy exercises, can be—at least potentially—sacramental activity; the importance of fully using all facets of physical therapy; and the idea that days spent in recuperation can be a time for deepened relationship with self, others, and a compassionate God. The sessions helped many patients mobilize their inner resources and assume greater personal responsibility for their healing and recovery.

is not just physical, but involves the whole person (body, mind, and spirit) and also that any good action, well done, can be a prayer."

### THE SACRED MOMENT

A key concept in holistic healing is that proper use of the present time is vital to recovery. Staff and patients must recognize the sacredness of the present moment, the *immediate now*. In *The Living Bread*, Thomas Merton emphasizes this idea: "In modern times we have lost sight of the fact that even the most ordinary actions of our everyday life are invested by their very nature with deep spiritual meaning."<sup>1</sup> Michael Downey in *Clothed in Christ* reinforces this: "All activity, even the most mundane, is, at least potentially, sacramental activity."<sup>2</sup>

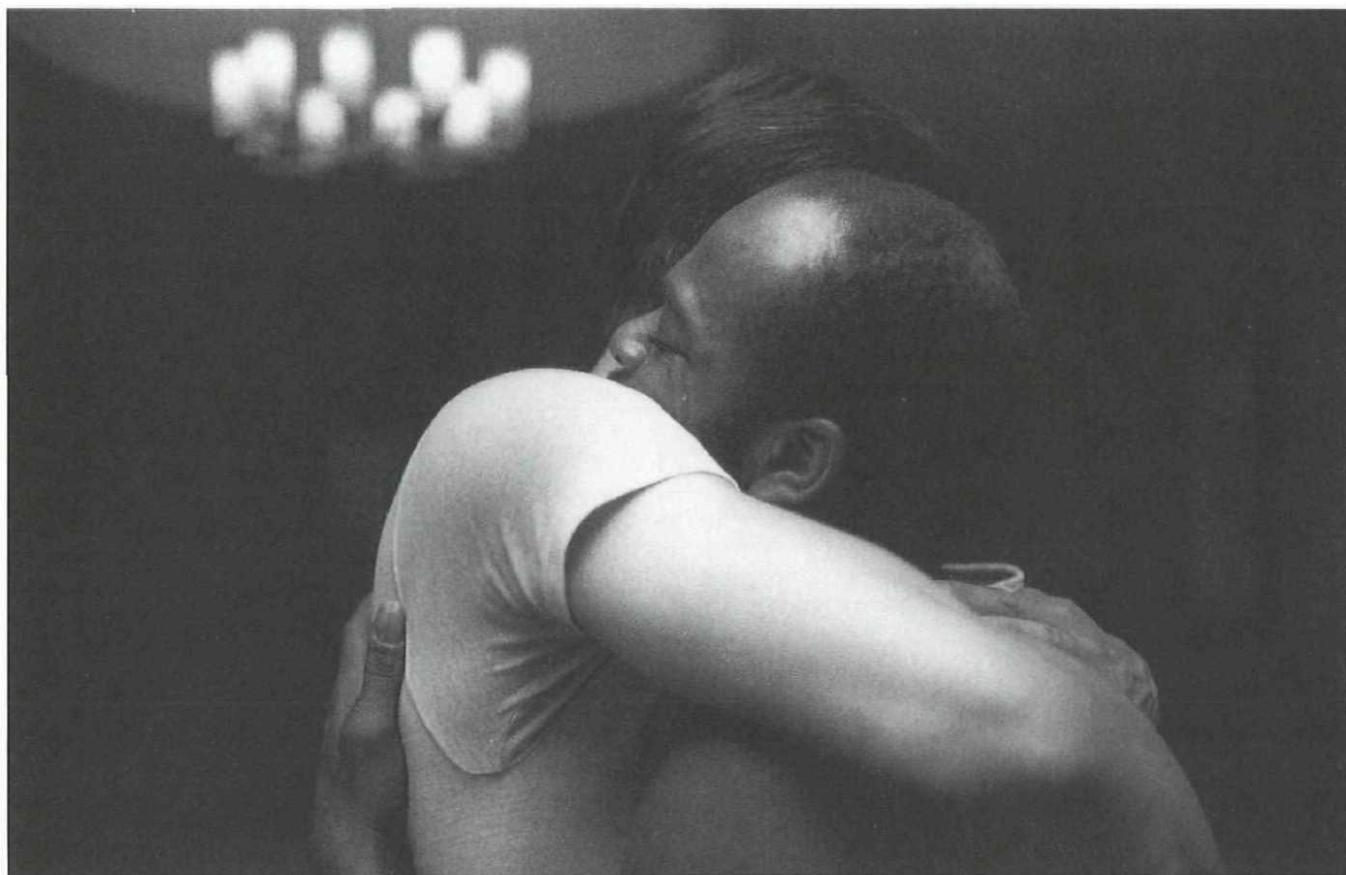
Yet anyone working on a physical rehabilitation unit knows how easy it is for patients and their support circle to allow the present time to slip away, while they nostalgically remember the past and look forward to a less painful and trying future. How can the pastoral care giver help them understand that these days of rejuvenative therapy can be—indeed should be—a time of healing growth, a time for new or deepened relationship

with self, others, and a loving God?

To effectively help patients and their loved ones make the most of the time spent on the rehabilitation unit, the chaplain must have full knowledge of each patient's physical condition: the diagnosis, prognosis, and day-to-day progress, as well as the immediate and long-range goals set by the rehabilitation team. This pertinent information is acquired not simply by reading patients' charts, occasionally hearing nursing reports, or catching rumors here and there, but by building a close, collaborative relationship with patients and the entire health team: therapists, nurses, dietitians, social workers, psychiatrists, and physicians. Such knowledge can be obtained only by regular attendance at staff meetings; conferences with patients, family, and staff; participation in discharge planning; and daily informal exchanges with patients and all who assist them.

To be knowledgeable about a patient's physical condition, however, is to know only a part of the whole. The chaplain needs empathic knowledge of both the patient's pain—"the distressing, hurtful sensations in the body"—and the patient's suffering—"a sense of anguish, vulnerability, loss of control and threat to the integrity of the self."<sup>3</sup>

*Patients discovered that acceptance of self and others has healing qualities.*



Photograph © Abraham Menashe

Clarifying the terms "pain" and "suffering" in his latest book, *What Kind of Life? The Limits of Medical Progress*, Daniel Callahan points out that there can be pain without suffering and suffering without pain.<sup>4</sup>

On the physical rehabilitation unit the patient's suffering is often linked to his or her attitude toward the disability. Negative feelings frequently

aggravate and intensify suffering. The chaplain, by engaging in sensitive dialogue, can ascertain how the patient views life now: with apathy or optimism? Courage or cowardice? Acceptance or anger? What changes in life-style should the patient anticipate? What are his or her concerns: loss of independence? Financial worries? Job insecurity? Curtailment of activities? Has the patient faced the realities of the situation?

#### AN ACCEPTING ENVIRONMENT

A chaplain cannot gain genuine insights into a patient's emotional or spiritual health by chance encounters. One of the chaplain's most challenging tasks is to create an accepting environment, a time, place, and ambience that will encourage patients to freely express their fears, frustrations, anxieties, hopes and dreams, pain and suffering, without fear of rejection or reproof. Listening with ears and heart to what is said and not said, being alert to what is revealed by body language, tone, speech rhythms, and silences, a chaplain learns how the patient feels about his or her situation. Adroitly phrased questions may evoke telling responses. What were some of the sorrows and problems faced in the past? What were the sources of strength and support during those difficult times? Did God enter the picture? In what way? What is his role in the current situation?

No matter what thoughts or feelings are expressed, the patient needs to know that his or her integrity as a person is respected and accepted. Gerald R. Niklas and Charlotte Stefanics, in *Ministry to the Sick*, assert that the patient, realizing he is understood and fully accepted with all his fears, anger, and discouragement, gains insights into himself and his situation. "Just knowing that he is understood, without being judged, is itself a tremendous source of strength that will enable the sick person to grow from his

# Suffering is often linked to one's attitude toward the disability.

experience. On the other hand, just using clichés, such as 'Don't worry. God will take care of everything,' has little or no value especially when the patient is angry with God, asking 'How can God be so cruel to me?'"<sup>5</sup>

Empowered by empathic knowledge of the pain and suffering endured by rehabilitation patients, the chaplain can foster holistic healing, integrating a spiritual dimension

into the lives of patients by helping them form a circle of love, a Community of Caring. The physical rehabilitation unit provides what Lowell G. Colston calls the essentials for true community: "physical, social, and inter-actional proximity, as well as a place where experiences and exercises, interests and goals are shared."<sup>6</sup> Caring, as defined by Callahan, "is to assure another that they remain important to others, that their illness has not deprived them of a life in the community. It is to ease their pain when possible, and then let them live with their frailty, whether of body, mind, or function."<sup>7</sup>

Joining in a Community of Caring gives patients the opportunity to share concerns, affirm each other's efforts, stimulate and encourage participation in all rejuvenative therapies, and ask God's healing love to sustain and bless each one's endeavors to regain as much function as possible while on the unit.

#### STARTING THE COMMUNITY

Shortly after my encounter with Goldie, I discussed with patients the possibility of forming a Community of Caring. I mentioned that each meeting would have a brief period for prayer and reflection, but no particular form of belief or religious practices would be observed. A respect for self, others, and God was the important factor, not affiliation with a Christian or non-Christian church.

Joe, a paraplegic, questioned: "I'm not certain what I believe about God, but at our Alcoholics Anonymous meetings, we refer to a Higher Power. Would that be OK?" His query prompted others to admit they were not at ease praying aloud. When they understood that our prayers would not be formal invocations but quiet reflections on how God has entered our lives and that no one was obliged to pray aloud or share their

thoughts, their misgivings were allayed. An excerpt from Harold Kushner's *Who Needs God?* was helpful:

Prayer is not a matter of coming to God with our wish list and pleading with him to give us what we ask for. Prayer is first and foremost the experience of being in the presence of God. Whether or not we have our requests granted, whether or not we get anything to take home as a result of the encounter, we are changed by having come into the presence of God.<sup>8</sup>

The concept that we are truly in the presence of God when we listen to, encourage, and affirm ourselves and each other was new to many, who also found much to ponder in Kushner's personal statement of faith:

I can believe in the reality of God despite the things that have happened in my family and in the families of people I care about, because I have seen Him work miracles. Not like the miracles of the Bible, suspensions of natural law, splitting the sea, bringing the dead back to life—God works miracles today by enabling ordinary people to do extraordinary things.<sup>9</sup>

At our first Community of Caring session, I suggested some guidelines. Participation was voluntary. No one was obliged to share thoughts, feelings, reflections, or prayers, but everyone was expected to give respectful attention to those who participated. Grievances about food, service, or staff were taboo. So, too, was self-pity. There was to be no playing what Rev. John Powell, SJ, terms the "PLUM" game: Poor, Little, Unfortunate, Me!<sup>10</sup> Permissible, indeed encouraged, was the game of TOT: Trivialize Our Trials or Tell Our Triumphs.

### **FORGIVENESS AND ACCEPTANCE**

Hopeful that one practical, immediate effect of the Community of Caring would be to help patients overcome feelings of inadequacy and low self-esteem, I asked whether some would be willing to share their deepest personal feelings about their disability at our next meeting. We would listen, reflect, and attempt to give insights that might nurture, affirm, and support.

At the next meeting, Joe spoke first. "You all know that I've lost both my legs and why: diabetes, then gangrene, surgery. You've encouraged me while I've been on the unit, scolding me sometimes when I rebelled against the new prostheses. You all know how bitter I get at times,

but what you don't know is how guilty I feel because I brought all this on myself. And what's worse, I knew that I was doing it and kept right on. Didn't stick to my diet, skipped insulin shots and medications, drank buckets of beer. It's not being a cripple that hurts so much and angers me now. It's that I did it to myself. And now there's no way to undo the damage."

A poignant silence was broken by Goldie's blunt comment: "Well, you can't unscramble scrambled eggs, so what can you do about it?" Responses came quickly. "Joe, when others hurt you, you forgive them. Now you have to learn to forgive yourself." His roommate offered sound advice: "You're too hard on yourself, Joe—always worrying about mistakes made in the past. Think more about what you're doing right, like sticking to your AA pledge." Peg's comment was the most nurturing: "You're so generous and thoughtful, Joe. Always sharing your magazines and tapes, bringing your TV to the lounge so we can all watch the Bears play. Now you have to learn to be generous to yourself. Forget the past; forgive yourself . . . and remember what the Lord said to a certain person: 'Neither do I condemn you.' If the Lord can forgive, so can you."

Discussion centered on learning to forgive oneself for past failings and accept oneself—not the self that used to be, before the disability, but the present self striving to maintain or regain strengths and skills necessary for today.

"But it's not easy to accept yourself when you no longer can accomplish what used to give you a feeling of self-worth," countered Bob, a stroke victim whose right side is paralyzed. "I used to be the handyman for the neighborhood—put up storm windows, installed air conditioners, cleaned gutters. Now my wife tries to do the chores, and I feel so useless." His statement echoed Rev. Henri Nouwen and Walter Gaffney's words in *Aging*: "There can hardly be a more alienated feeling than that which believes, 'I am who I was.'"<sup>11</sup>

Sensing that many in the group had similar feelings of low self-esteem, I suggested that each one take time right then to reflect on his or her priorities and values. To what extent did these hinge on personal accomplishments? Material success, financial and social status, acquisitions? What in the past had brought genuine satisfaction? Lasting joy? Peace and contentment? Had these changed because of the present disability?

After quiet reflection many agreed that although in the past some things, such as financial security, had seemed the ultimate goal, there were some priorities that no handicap, pain, or suffering could change. "Come to think of it, I still have everything I value most," Bob admitted. "My wife's love—and the kids. The neighbors still

talk about how I helped them. I'm glad I did what I could when I was able."

This and similar comments prompted a lengthy discussion at our next gathering of what is meant by authentic self-acceptance. Patients came to the conclusion that self-acceptance means sincere acknowledgment of who one is, personally, spiritually, physically, culturally, socially, educationally, intellectually, historically. As Fran Ferder wrote:

Genuine self-acceptance is much more than a simple recognition of the self, strengths and weaknesses, gifts and limitations, the shadow self and the one revealed to others. Self-acceptance invites us to love ourselves so much that we will not let ourselves be less than we can be. Self-acceptance is the willingness to claim and to love who we are and the commitment to push that self-definition to its greatest possibility.<sup>12</sup>

Our Community of Caring session ended with reflection on the words of Paul Tillich:

We experience moments when we accept ourselves because we feel that we have been accepted by that which is greater than we. If only more such moments were given to us! For it is such moments that make us love our life, that make us accept ourselves, not in our goodness and self-complacency, but in the certainty of the eternal meaning of our life.<sup>13</sup>

In the following weeks, several patients further explored the concept of self-forgiveness and self-acceptance by reading and discussing pertinent chapters in works by Jesuit Fathers Dennis and Matthew Linn.<sup>14</sup> As individuals grew in self-awareness and self-acceptance, they also became increasingly sensitive to other patients' pain, suffering, losses, and fears, as well as their courage and determination. Self-acceptance helped many to accept others. Self-revelations and discerning comments made during Community of Caring sessions, in an atmosphere of respect and openness, fostered empathic understanding of self and others and, ultimately, God.

### PRAYER IN DAILY LIFE

The idea that time, when properly used, is a form of prayer was another revelation to many, who were accustomed to think of prayer as church attendance, Scripture reading, and recitation of creeds and invocations. The concept that spirituality is not one dimensional, but can (and should) permeate every facet of daily life, evoked questions and comments but was accepted by many

after they grasped the idea that when one sincerely strives to praise and glorify God by living rightfully and doing one's best, then each good action truly honors him and is, indeed, a prayer.

Patients had no difficulty suggesting ways of integrating spiritual dimensions into the regimen of therapies on the rehabilitation unit. Their responses were succinct and practical: arrive on time for all sessions, even those you do not like; participate wholeheartedly; listen carefully to instructions; be patient while waiting for assistance; cooperate even though the exercises are painful; do as much as possible for yourself.

Elaborating on Downey's idea that all activity, even the most mundane and trivial, is at least potentially sacramental, discussion centered on the importance of fully using every facet of rehabilitation therapies. Provocative questions were raised. Convinced of your own uniqueness and worth, do you use every opportunity to develop your full potential? Do you mobilize your inner resources, such as trust in your own strength and willpower, to enable you to participate wholeheartedly in all rejuvenative therapies? Rest, diet, socializing, prayer, quiet time for yourself—are these times of healing the inner self?

On several occasions, when stressing the importance of using the present time to its fullest, I used the term, "the sacrament of the moment." Sam, hitherto a silent member of our Community of Caring, questioned: "Instead of 'sacrament,' could we say 'the sacredness of time?'" He explained that Judaism is a religion aiming at the sanctification of time, and he elaborated by sketching briefly the main idea in Rabbi Abraham Heschel's essay *The Sabbath*, which examines how in the Jewish tradition the idea of holiness was shifted from space to time. Heschel questions: "What was the first holy object in the history of the world: a mountain? an altar?" The answer, he states, is found in the first chapter of the Book of Genesis: "And God blessed the seventh day and made it holy."<sup>15</sup>

The importance of making every minute spent on the rehabilitation unit a time of progress, recovery, and holistic healing was captured in Sam's enunciation of Heschel's profound statement: "Every hour is unique; and the only one given at the moment, exclusive and endlessly precious."<sup>16</sup>

### A NETWORK OF BONDS

Community of Caring participants suggested many topics for discussion, including personal responsibility, use of leisure time, and how to mobilize inner resources. Many talked frankly about feelings of depression, anxiety, and anger (see **Box**). The discussion helped patients deal with their negative, self-destructive thoughts.

Many patients also grew in their capacity to experience concern, care, and interest in fellow patients. Affirmation of others was evinced in tangible ways: a smile of approval or gratitude; words of praise for completing an exercise (or at least trying); a complaint suppressed, self-pity stifled; a hug to show sympathy, support, camaraderie.

As the group shared thoughts on ways they experienced God's healing presence through the support of others, they formed a network of affectional bonds wherein they felt free to express their innermost thoughts; they were forging a true Community of Caring. Strengthened by empathic knowledge and understanding of each other's needs and goals, patients discovered that

acceptance of self and others has healing qualities, not because a disability was remedied and suffering alleviated, but because these were shared with others who affirmed their efforts to make use of *the present moment*, imparting a sense of worth, deepening their hopes, reverencing the personhood of each patient. Affirmed by self and others, members of the Community of Caring said they experienced a closer relationship with the creator and his world.

#### GROWTH AND HEALING

The topics, strategies, and dynamics that made the Community of Caring a success on the physi-

*Continued on page 70*

## FASTING OF THE MIND

One Community of Caring session at Mercy Hospital, Chicago, helped patients on the physical rehabilitation unit deal with their feelings of depression, anxiety, and anger. Susan, a burn victim, confessed: "I get blue when my three teenage daughters don't visit every day. When I show them how I'm using my legs and arms again, they say, 'Mom, we can't bear to look at those ugly scars.'"

This and similar disclosures led to a session on changing self-destructive, negative attitudes and behaviors, replacing them with life-giving attitudes and values. Many found help in Rev. Bernard Tyrrell's theories of Christotherapy, such as mind-fasting ("Exploring Christotherapy," *Human Development*, Summer 1984; and *Christotherapy II*, Paulist Press, Mahwah, NJ, 1982). Fasting of the mind, heart, imagination, and spirit, Fr. Tyrrell explains, starts when

an individual seeks with the help of God to fast from, or to release, those fantasies, beliefs, assumptions, and behaviors that he or she understands to be self-destructive, self-defeating, and misery-creating. Every recovering addict and neurotic, for example, comes to see and verify in a gut fashion that there can be no room in his or her life for self-pity and resentment. These activities are just as deadly and harmful to the psyche and spirit as holding a burning object in one's hand. Self-pity is truly "sickening" and the minute it is spotted, the recovering neurotic or addict lets go of it, fasts from it, freely, not in a repressive fashion or through a blind exercise of sheer will power but as a result of enlightened diagnosis. ("Exploring Christotherapy," pp. 37-38)

Clarification and reflection on Fr. Tyrrell's theories about mind-fasting stimulated discussion. Many grasped and accepted the basic concepts of mind-fasting, as evidenced by their responses to the query: How could the practice of mind-fasting help you be a better person now? Susan answered that she

intended to "fast" from the idea that her daughters should visit her daily; she would allow them to make their own decisions and try to be happy with whatever they decided.

Jane—who earlier had admitted she talked to herself, silently repeating a list of grievances, hurts, and disappointments—said she would "fast" from this inner, negative chatter, focusing instead on the good aspects of her life. "Being here, getting help, feeling that others are concerned about me are blessings I should think about," she concluded.

Their responses incorporated aspects of "spirit-feasting" described by Fr. Tyrrell:

The person who is fasting from some destructive form of mental activity or behavior needs to fill in the resulting gap or vacuum by discovering some authentic, life-enriching value to feast on. When a person is fasting from self-pity, he or she needs to appreciatively delight in, feast on, some value such as the experience of new-found physical health or, in the case of an addict, the happiness of sobriety.

Of course, everyone is called to such spirit feasting daily. I recommend to people that before going to a concert or meeting a friend, they prayerfully ask God to let the beauty shine forth during the concert or in the encounter. ("Exploring Christotherapy," p. 38)

Not everyone in our Community of Caring found the basic ideas of Christotherapy (mind-fasting and spirit-feasting) helpful, but resulting discussions reinforced the truth that healing and growth involve self-transcendence that opens one to other values, to other people, and ultimately to God, while negating self-referential thinking, desiring, and acting, often the result of deeply imbedded suffering and pain. Many adopted Fr. Tyrrell's idea of "feasting" as a practical way to quell negative, self-destructive thoughts by focusing on pleasant happenings: a phone call, a card, visits, success in therapy, affirmation from staff and peers.



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## IMPROVING GOVERNANCE

*Continued from page 57*

view with respect to their particular goals and priorities.

### COMMITMENT

The strategies set forth in "A Plan for the Healthcare Apostolate" are based on the conviction that local governance has a vitally important role in large, geographically dispersed, multiunit organizations, and that the quality of governance within DCNHS-East Central could and should be improved. The steps outlined in this article have clarified the authority and responsibilities of the local boards and strengthened their performance.

However, DCNHS-East Central is committed to ongoing evaluation to further improve the quality of governance. Through a commitment to continual improvement, the system hopes to achieve and maintain excellence in the performance of its local boards and the healthcare facilities for which they hold fiduciary responsibility. □

### NOTES

1. Daughters of Charity of St. Vincent de Paul-East Central Province, "A Plan for the Healthcare Apostolate: An Active, Visible, and Vocal Witness," Evansville, IN, 1981 (revised 1984).
2. See, for example, Linda Yoder, "Mentoring: A Concept Analysis," *Nursing Administration Quarterly*, vol. 15, 1990, pp. 9-19; E. Sellner, *Mentoring: The Ministry of Spiritual Kinship*, Ave Maria Press, Notre Dame, IN, 1990.
3. "A Plan for the Healthcare Apostolate," p. 18.
4. Lawrence Prybil, "A Perspective on Local-Level Governance in Multiunit Systems," *Hospital and Health Services Administration*, vol. 36, 1991, p. 10.
5. Daughters of Charity National Health System, "Basic Roles of Sponsorship, Governance, and Management in DCNHS," St. Louis, 1991.
6. "A Plan for the Healthcare Apostolate," p. 17.
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## A COMMUNITY OF CARING

*Continued from page 53*

cal rehabilitation unit could be successfully adapted in other hospital units, such as cardiac, urologic, diabetic, and substance abuse programs. Illness and suffering do not limit one's capacity for growth in physical, mental, emotional, or spiritual domains; healing occurs only when the whole person is involved. When patients gather together in a Community of Caring, pain and suffering lessen; growth and healing occur. □

### NOTES

1. Thomas Merton, *The Living Bread*, Farrar, Straus & Cudahy, New York City, 1956, p. 126.
2. Michael Downey, *Clothed in Christ*, Crossroad, New York City, 1987, p. 126.
3. Daniel Callahan, *What Kind of Life? The Limits of Medical Progress*, Simon & Schuster, New York City, 1990, p. 143.
4. Callahan, p. 143.
5. Gerald R. Niklas and Charlotte Stefanics, *Ministry to the Sick*, Alba House, Staten Island, NY, 1982, pp. 15, 16.
6. Lowell G. Colston, "The Handicapped," in Howard Clinebell, Jr., ed., *Mental Health through Christian Community*, Abingdon Press, Nashville, 1965, p. 154.
7. Callahan, p. 147.
8. Harold Kushner, *Who Needs God?* Summit Books, New York City, 1989, p. 148.
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10. John Powell, lecture at Mercy Hospital and Medical Center, Chicago, November 1986.
11. Henri Nouwen and Walter Gaffney, *Aging: The Fulfillment of Life*, Doubleday, Garden City, NY, 1974, p. 40.
12. Fran Ferder, *Words Made Flesh*, Ave Maria Press, Notre Dame, IN, 1986, p. 168.
13. Paul Tillich, quoted in "Priestly People," newsletter of the Servants of the Paraclete, January 1987, p. 2.
14. Dennis and Matthew Linn, *Healing of Memories*, Paulist Press, Mahwah, NJ, 1974; *Healing Life's Hurts*, Paulist Press, Mahwah, NJ, 1978; *To Heal as Jesus Healed*, in collaboration with Barbara Shlemon, Ave Maria Press, Notre Dame, IN, 1978.
15. Abraham Heschel, *The Sabbath*, Farrar, Straus & Giroux, New York City, 1951, p. 8.
16. Heschel, p. 9.