

# COMMUNITY CARING FOR THE FAMILY CAREGIVER: THE DEVELOPMENT OF A VIDEO OUTREACH PROGRAM IN ISRAEL

EDWARD PRAGER, PH.D

*School of Social Work, Tel Aviv University, Ramot Aviv, Israel*

*In Israel, as elsewhere, spouses and adult children caring for their frail aged are themselves "hidden patients," whose unique needs are largely overlooked by the human services community. This article describes a video outreach project in Israel, intended to provide groups of family caregivers with the educational and supportive guidance needed to help them to cope more effectively with their burdens, and to alleviate feelings of alienation, powerlessness, and resentment.*

## INTRODUCTION

Increased longevity in Israel, as in other developed countries with advanced medical services, is a cause for celebration but also for new alertness to unforeseen related problems. Harel and Harel,<sup>1</sup> studying the American Jewish community, find that demands for formal services are increasing, reflecting the fact that many families may be less willing or able to provide informal support to their frail elders, especially as adult children—often middle-aged or even "young-old" themselves—are understandably preoccupied with their own declining capacities and may not be able to serve as significant sources of support. Families in Israel, owing both to social norms of responsibility towards

elders within the Jewish culture as well as to geographic stability and relative absence of physical dispersion among elders and their kin here,<sup>2</sup> continue to be the primary active caregivers to aged kin.

But feelings of resentment ("... what kills me is the never-ending routine of it all... it'll only get worse"), guilt ("How do I deal with my conscience?" and "Why must I feel guilty about taking my husband out for two hours to sit and clear our heads?"), and alienation ("... we want to be free of rotten feelings and there is no one to talk to..."), directed toward the human services community here are testimony to the fact that the family, traditionally the first and most often last line of defense in the care of its frail aged, has received surprisingly little from us by way of outreach and help, training and education. The need of the informal family network to be helped in assuming its burden of caregiving to frail aged kin is not only apparent, it is most likely greater in scope than any of our current estimates. As Kahana and Kahana rightfully note, "the challenge is the development of creative services which do

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1. Zev Harel and Bernice Harel, "Coordinated Services for Older Adults in the Jewish Community," *Journal of Jewish Communal Service*. Vol. 54, No. 2, 1978. pp. 214-219.

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2. Boaz Kahana and Eva Kahana, "Jewish Aged and their Families: Cross-National Perspectives." Paper prepared for the Symposium on Aging in the Jewish World. The JDC—Brookdale Institute, Jerusalem, June 30 - July 5, 1985. p. 20.

not replace the family but work with it and complement it."<sup>3</sup>

The purpose of this paper is to share some thoughts on family caregiving, in general, and to describe briefly the rationale and development of a community-based service component, designed to help the caregiver with his or her caregiving task. The Family Care Guidance Project, a video outreach program sponsored by two major national organizations, is conceived as extending, through the medium of video communication, the educational and emotional support resources of the community into the lives of those family caregivers who are shouldering the burden of care for their frail aged, often in silence and with the feeling that they have been forgotten by the professional community. Through the combined educational and psychosocial approach to family caregiving, a major impact goal of the Project is to reduce feelings of alienation, isolation, deprivation and helplessness so often experienced by the adult children and spouses working the "36-hour day" in the service of their frail aged.

#### DEMOGRAPHIC AND HISTORICAL BACKGROUND TO FAMILY CAREGIVING

As of 1980, some 75,000 aged, or 25% of the population over the age of 65 in Israel were living in multigenerational households.<sup>4</sup> Reporting on a major recent study, Davies<sup>5</sup> noted that a total of 22% of the aged sample population were partially or

completely dependent upon others for help in carrying out activities of daily living. In the most rapidly growing sector of the population—those over 80—over 20% were found to be either bed- or house-bound. It is projected that, by 1990, over 35,000 Israelis over the age of 65 and living in the community will be partially or completely dependent upon others for daily functioning; one out of every three aged will require personal care services.<sup>6</sup>

Unlike other countries in which the aging of society has been a gradual process, Israel has experienced a recent rapid aging of its population due to its unique demographic history. During the pre- and post-World War II periods, including the period immediately following this country's independence in 1948, this demographically young society saw the influx of large groups of young immigrants, including idealistic pioneers and Holocaust survivors. Today these cohorts have reached old age together. In some of the veteran agricultural settlements (*kibbutzim*), as many as 40% of the members have attained the age of 65. Coterminous with the absorption of these groups, mass immigrations of refugees from the Arab countries occurred during the late 1940's and throughout the 1950's, tripling the country's total population during a 15-year period and constituting a primary challenge to its health, education and welfare resources.

These demographic developments, combined with ongoing problems of defense and national survival, account for much of the lack of preparedness in dealing with the problems of an aging population, in

3. *Ibid.*, p. 25.

4. Yaakov Kop and Haim Factor, "Changing Characteristics of the Israeli Population and the Utilization of Health Care Services," *Israel Journal of Medical Sciences*, Vol. 21, No. 3, 1985. pp. 205-211.

5. Michael Davies, "The Graying of Israel—Implications for Health and the Need for Services," *Israel Journal of Medical Sciences*. Vol. 21, No. 3, 1985. pp. 197-202.

6. Jack Habib and Haim Factor, *The Elderly in Israel: Background Material Prepared for the Annual Conference of the National Association of Pensioners*—16-1-1984. Jerusalem: Brookdale Institute of Gerontology and Adult Human Development in Israel, 1984.

general, and for those requiring community-based long-term care services, in particular. Clearly, Israel's overstrained economy has not been able, and will not in the foreseeable future be able, to finance the large-scale expansion and development of community and institutional resources required in order to alleviate what is fast becoming a situation of crisis proportions in the long-term-care health and welfare sectors. One obvious implication is that the pressures on thousands of primary caregivers and the tens of thousands of related family members affected by caregiving efforts in non-institutional, informal care home environments will increase significantly.

In effect, the growing private concerns for aging kin have become a community problem in Israel today, for in a country which is small geographically, the nation in many respects *is* the community. In a national population characterized by a high degree of social intimacy, emotional expressiveness, commonality of purpose, and awareness of national continuity, the problems of the many become the concerns of the society. Moreover, this society is characterized by an intensity of family loyalty and sense of responsibility toward family members in general, and toward the sick and aged in particular. Intrinsic to Jewish tradition is the tenet that all of the House of Israel is as one family, and its members bear collective responsibility for one another. Yet, within the community of professional helping services, in which formal networks are severely limited in their ability to meet the needs of both family caregivers and their aged, families understandably feel alone and helpless in their responsibilities toward aged dependent parents or spouses. Perhaps at no time in the short history of modern Israel has there been greater need for a variety of innovative approaches in order to cope with the fast growing community burden of the long-term care of its aged.

#### EASING THE PRIVATE BURDEN THROUGH COMMUNAL RESPONSIBILITY

In a country which has prided itself in its strong sense of familism and communal responsibility for the welfare of its citizenry, manifested particularly in such areas as mother-and-baby care and pre-school day care facilities, among others, it is fortunate that a growing sector of the population seems to share the feeling that they have been forgotten in their efforts to care for their own. The often sudden illness of a parent or a spouse is such a significant source of stress that it can throw the entire network of interpersonal relationships within a family out of equilibrium. Each caregiver, in his or her own unique way, instinctively seeks either to return to the premorbid interpersonal, familial, and social equilibrium, or to establish a new homeostasis between the various human and environmental components of the caregiving situation.

In many cases, perhaps most, this is not accomplished without an array of emotions displayed toward the recipient of care and diffused toward the familial and social surround as well. Often the strategies used for coping with the caregiving situation are themselves the sources of additional stress above and beyond caregiving (early retirement to care for the patient, shared living arrangements and recruitment of grandchildren as "baby sitters," to mention a few). Without the necessary backup and support, in the absence of a sense that there are people and organizations to lean on, the loneliness of the long-term caregiver has become a weight of increasing intensity and concern.

Paralleling the structural and normative changes taking place in such social institutions as the family in developed countries, there are indications that the Israeli family is evolving into a more nuclearized struc-

ture as the temporal emphasis of society shifts from past and future to a preoccupation with its present.<sup>7</sup> The implications of the normative shift from collectivism to individualism are such that traditional assumptions about family inter-relationships and care of the aged may be less valid than they were just a short generation ago. Today, with the quantum leap in the numbers of older Israelis living in a society characterized by increased individualism and a "here-and-now" orientation to time, new realities are presenting new dilemmas. As the Israeli caregiving family, similar to its western counterpart, shows signs of becoming increasingly vulnerable to strains such as those related to long-term caregiving burdens, its roles and functions with respect to the care of its aged has scarcely been questioned. As in so many other communities throughout the world, the Israeli community has not as yet succeeded in defining the relationship between the family—the major source of affective caregiving support to the frail aged—and the provision of formal, organizational services. And while economic constraints have severely limited the expansion of community and institutional long-term care services, the necessary educational and back-up supports for those families who choose, or who must continue, to care for their frail aged in the community have not, as yet, been forthcoming. It is with respect to these "hidden patients" in our midst that we must begin concerning ourselves with the question of who is caring for the caregiver?

Some attention has been given recently to the work of Litwak and Kulis<sup>8</sup> who

argue that the long-term care patient cannot receive optimum care unless there is a joining or sharing of functions between the informal and formal care networks. Their central premise is that total care, whether in the community or institution, can be provided only through the "balanced coordination" of tasks, kin generally being in the best position to meet those highly personalized, socio-affective care needs congruent with the roles, functions and capacities of the kin group network. Clearly what is called for is a back-up system, by which the care of the elderly frail can be shared among a number of professional and lay people.<sup>9</sup>

Following the general directions and trends in long-term care developments elsewhere, the Israeli human services community has begun to respond to the critical needs in the long-term care of its aged, on legislative, planning, and practice dimensions. There is an increasing awareness within the human services community that the adult child and spouse are our most important actual and potential sources of manpower in the long-term care of the frail aged, and that they represent *the* vital link between the older person and the formal organizational network. There is also an increasing realization that, while the intervention of the community at large in meeting the needs of the elderly is inevitable, the formal network can never be, and must be considered, a complete substitute for the family. However, notwithstanding the growing awareness that the most practical solutions to the increasing private and public burden of long-term care involve a partnership between communal and familial arenas of service, outreach to the family caregiver as the "hidden client" has been slow to evolve.

7. See, for example, Yona Cohen, "Should Social Work Be Israelized?" *Society and Welfare* (Hebrew), 1978. pp. 15-24

8. Eugene Litwak and Steve Kulis, *The Dynamics of Network Change for Older People: Social Policy and Social Theory*. Preprint Series #74. New York: Center for the Social Sciences at Columbia University, 1981.

9. Eugene Litwak, "Research Patterns in the Health of the Elderly," in E. Borgatta and N. McCluskey (eds.), *Aging and Society*. Beverly Hills: Sage Publications, 1980, pp. 79-130.

## REACHING THE "HIDDEN CLIENT" BY VIDEO:

Evidence drawn from the United States and Israel, among other nations, points to the fact that, in the majority of caregiving situations, the primary burden of care usually rests upon the shoulders of a single caregiver, most often a daughter or a spouse.<sup>10</sup> Moreover, studies comparing children and spouses indicate that both experience similar kinds of stress, particularly when children, like spouses, are left alone to cope with the disabled person.<sup>11</sup>

There is a realistic and pressing need for social agencies to respond both to the caregiver's sense of inadequacy and to his or her desire to assist the frail relative. Perhaps more important than concrete assistance to caregiving families is teaching them how to assist effectively and how to cope with the various stresses of long-term caregiving. Specifically, a community-based caregiver outreach program may answer both needs for knowledge in the area of instrumental care as well as for emotional support in the area of affective care, both the respect to the patient as well as to the caregiver him- or her-self. And as a growing practice literature appears to indicate,<sup>12</sup> a group orientation

which facilitates the development of a peer support system among caregivers appears to have salutary effects upon participants sharing similar burdens.

Based upon a similar project, in which this author participated in Cleveland in the late 1970's,<sup>13</sup> the Family Care Guidance Project was initiated and developed in 1982 by the *ESHTEL*—Association for the Planning and Development of Services for the Aged in Israel—together with the National Insurance Institute (*HaMosad L'Bituach Ha'Leumi*). Undergirding the concept of the Project was the thinking that the time was long overdue for a service which would help both to legitimize and to answer the unique needs of the family caregiver. Designed ultimately to reach the "hidden clients," the family caregivers, in their neighborhoods and communities, the main objectives of the Project were to:

1. teach those skills and facilitate the kind of social and emotional sharing of problems, within a group structure, which are requisite to effective functioning in the caregiving role;
2. maintain the mental health and integrity of the caregiving family through the establishment of an educational and sup-

10. See, for example: Beth J. Soldo and Jaana Myllyluoma, "Caregivers Who Live with Dependent Elderly." *The Gerontologist*. Vol. 23, No. 6, December 1983. pp. 605-611; Marjorie H. Cantor, "Strain Among Caregivers: A Study of Experience in the United States." *The Gerontologist*. Vol. 23, No. 6, December 1983. pp. 597-604; Hal L. Kendig and Don T. Rowland, "Family Support of the Australian Aged: A Comparison with the United States." *The Gerontologist*. Vol. 23, No. 6, December 1983. pp. 643-649.

11. Benjamin Danis and Barbara Silverstone, "The Impact of Caregiving: A Difference Between Wives and Daughters?" Paper presented at the 34th Annual Meeting of the Gerontological Society, November 1981.

12. See, for example: Pennie M. Cohen, "A Group Approach for Working With Families of the Elderly." *The Gerontologist*. Vol. 23, No. 3, June,

1983. pp. 251-253; Noreen M. Clark and William Rakowski, "Family Caregivers of Older Adults: Improving Helping Skills." *The Gerontologist*. Vol. 23, No. 6, December, 1983. pp. 637-642; C. P. Hausman, "Short-Term Counseling Groups for People with Elderly Parents." *The Gerontologist*. Vol. 19, No. 1, February, 1979; Lawrence W. Lazarus, Bridget Stafford, Kathleen Cooper, Bertram Cohler and Maurice Dysken, "A Pilot Study of an Alzheimer Patients' Relatives Discussion Groups." *The Gerontologist*. Vol. 21, No. 4, August, 1981. pp. 353-358.

13. Iris Gold of the Cuyahoga County Community College, Cleveland, Ohio conceived and developed a program of video outreach to family caregivers, entitled "Family Training in Non-Institutional Care." The content and structure of that program, which culminated in the videotaping of lectures and discussion, served as the basis for the Israeli project discussed in this paper.

portive presence and intervention on the part of organizations representing the formal network of long-term care services, and

3. alleviate, through an educational and guidance-oriented program, those alienating conditions which Naparstek and Haskell<sup>14</sup> outline in their analysis of urban policies and neighborhood services.

### The Product

The content of the videotaped Family Care Guidance Project contains educational material pertaining to the learning or improvement of those tasks and skills most closely associated with the roles and functions of the family care provider. Examples of such material include the presentation of educational material acquainting the caregiver with the more common aging and disease processes, their causes and symptomatology, and emphasizing the role of the family member in the identification and reporting of changes in the patient's condition. Similarly, a lengthy segment on home nursing familiarizes the caregiver with nursing techniques and clinical observations, as well as with clinical procedures which can be learned or improved upon in order to increase patient comfort while decreasing caregiver discomfort with some of the less pleasant home care routines.

One example of the latter is that of the care of the incontinent patient living with family. The thought of using disposable diapers in order to cope with the problem was apparently anathema to many in the group for whom the problem was an actual one. Their attempts to deal with the situation often resulted in irritation, anger, and a sense of revulsion at having to clean urine and feces from floors and sheets. They felt that the use of a diaper

was infantilizing and degraded the integrity of the parent or spouse. The use of the diaper was introduced and explained in such a way as to mitigate the negative feelings associated with the use of such an aid. Group members were helped to understand and accept the fact that in most instances the use of a disposable diaper not only would greatly reduce caregiver discomfort with such chores, but would also contribute to the physical and social comfort of the patient.

The product of the two-year developmental phase of the Project, which was overseen by a broad-based inter-organizational steering committee, to which the writer has been a consultant, takes the form of 17 videotaped quasi group encounter sessions, each devoted to one or more of six major long-term caregiving issues and problems confronted by family caregivers:

1. the meaning of chronic illness
2. home nursing
3. physical activity
4. intergenerational/interpersonal relationships in caregiving
5. the role and meaning of spirituality in long-term care
6. the interface between formal and informal networks; towards the establishment of a partnership.

An introductory film, consisting of an explanatory narrative and short, illustrative segments from some of the videotaped group sessions, was designed to "talk to" the family caregiver, acquainting him or her with the nature of the Project in general, and with the idea of a mutual sharing of concerns within a group milieu specifically.

Each two-hour modular unit consists of a taped lecture given by a professional in a particular area of long-term care, followed by related discussion and reactions, co-led by the group facilitator and the visiting lecturer. Spontaneous monologues and dialogues, often of a highly volatile and

14. Arthur, Naparstek and Chester Haskell, "Urban Policies and Neighborhood Services," in Daniel Thursz and Joseph Vigilante (eds.), *Reaching People: The Structure of Neighborhood Services*. Beverly Hills: Sage Publications, 1978. pp. 59-94.

sensitive nature, are purposefully incorporated into most of the videotaped presentations so that each unit might be not only informative and educational but also stimulate discussion and provide an emotional trigger for helping family members participating in groups of this nature in the future to share and support each other in their caregiving experiences. When incorporated into group work efforts with family caregivers, the use of the videotapes is expected to comprise a major component of outreach efforts, especially when used in communities where qualified professionals in geriatric medicine and nursing and in gerontological social work are in short supply.

### Project Development

Development of the Project called for a two-stage process; the first stage entailing a "dry run," or rehearsal, with one group of caregivers; the second stage, incorporating necessary modifications and alterations to concept and structure, being videotaped with a different group of caregivers, selected in similar fashion to the first group. Both groups of caregivers were drawn from the Kiryat Ono<sup>15</sup> suburb of Tel Aviv. The first group of 13 participants met for weekly sessions over a three-month period. For this group two observers kept detailed notes, recording individual and group reactions to lecturers and the relevance of lecture content and participation of members within the group context. Early cautions and anxieties by the staff, to the effect that the group milieu, as a helping intervention foreign to Israelis, would considerably limit and inhibit their contributions, proved to be groundless. In fact, the extent to which group participants shared material of a

highly intimate nature with each other and with staff was most revealing.

It became apparent relatively early in the career of the group that the feelings of loneliness and helplessness on the part of the family participants were so strong and so ready to surface that the need and opportunity to share with others within a supportive group milieu, for the most part, nullified the effects of age and cultural and experiential differences as potential barriers to individual involvement in the group process. One of many documentations of the actual and potential explosiveness of the caregiving situation, with its concomitant sense of aloneness with the problem, feeling of helplessness, and need for emotional catharsis, serves to typify the spontaneous ventilation in the group: "I had a terrible blow-up with my mother after feeling guilty for everything I was doing or was not doing for her. I stormed out of the house, ran to my father's grave and told 'the piece of marble' the whole story; and then I cried uncontrollably."

In the winter of 1985, with personnel and content changes having been made where necessary, the second, videotaped group began the first of seventeen weekly sessions, coordinated by a group facilitator. Beyond the first two warm-up sessions in front of the cameras, the same spontaneity and candor which characterized the first group were observed in the second group of participants whose cultural origins spanned both eastern and western hemispheres. The dominant themes voiced by these Yemenite, Polish, Iranian, Romanian, as well as Israel-born caregivers, whose ages ranged from the mid-30's to the late 60's, bore striking resemblance to the major problem areas recorded for similar groups of American caregivers. The frictions and often angry exchanges between caregiver and patient, triggering feelings of guilt and related psychic stress in the family care provider was a predominant concern ("How much

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15. The author wishes to acknowledge the invaluable assistance rendered to this project by Mrs. Esther Yakovits, formerly Director Kiryat Ono Division on Aging, and by Mr. Isser Baumol, Director, Kiryat Ono Department of Community Services.

do I owe my father just because he's my father? . . . How can you touch him and kiss him when you know deep down inside you that you have no love for him?"). Similarly shared were feelings reflecting emotional exhaustion and need for relief or respite from the burden of caregiving, if only for short intervals ("In my case it's psychological death;" and "I no longer have any privacy" . . . . "I feel I've lost a part of my life" . . . . "We are all in a prison.").

A considerable amount of anger was ventilated in the direction of family members who, it was felt, had not assumed their equitable share of the caregiving burden. Similar sentiments were directed towards health and welfare workers, whose "apathy" and "detachment" from the needs of caregivers were noted by many. What they felt to be a lack of professional understanding and responsiveness was expressed as an indictment against the human services community generally. Perhaps most significant was the fact that such feelings indeed surfaced and were freely expressed and, as recorded by the video cameras, will give support and legitimacy to similar feelings experienced by other caregivers viewing the tapes within groups of their peers.

An interesting observation made by the Project staff was the effect of the group experience upon the members of the five-man television crew. Though they had begun their work at a considerable emotional and social distance from the subjects they were filming, by the tenth session crew members had become so identified with the particular situations and the effects of burdens upon individual members of the group that their own emotions began to be evident. Following taping sessions both the producer and director sought out specific caregivers and the lecturer present in order to discuss further—even to argue—certain issues which had been brought up during the evening.

As their personal, non-professional involvement became manifest, they became increasingly sensitive to the dynamics and content of the group experience. Consequently their camera increasingly sought out and focused on covert, non-verbal gestures and nuances of behavior which ultimately substantially enhanced the visual documentation of the sessions.

#### IMPLEMENTING AND EVALUATING THE VIDEO OUTREACH PROGRAM

The implementation and evaluation of the Project is seen as comprising three serially related organizational efforts:

##### "Selling"

Perhaps the most formidable of the project-related tasks to date is the selling of the video series and the idea of outreach to groups of caregivers in their own communities to professional care providers, program planners and regional administrators of health and welfare services. Though the use of groups has found considerable acceptance in the helping community here in recent years, there is still a tendency to feel "safer" with the individual casework approach. This is more a function of professional unfamiliarity and insecurity with the group medium than it is an ideological issue. Whatever the case may be, such a project, even for a trial period, requires a broad-based endorsement by health and welfare personnel in order to get it off the ground coterminously in several communities.

To the extent that such support is needed, the first of what will most likely be many workshops and presentation meetings has already been held, with positive results. Discussion of the burdens of the "hidden patient" and of the appropriateness of the group milieu as a medium for learning and sharing and the viewing of representative films from the



series comprise the content of such task-related professional meetings. If the goals of these meetings are met group leaders will be trained in the use of the video series as a complement and supplement to their work with groups of caregivers throughout the country.

#### Implementation

Current plans are to make this service component available to municipal health, welfare and other community facilities throughout the country, for use in conjunction with existing programs or with programs which will be originated to reach out to the family caregiver. Through the skills of a group facilitator and the technology of video communications, issues and problems related to caregiving will be brought into club rooms, community centers, and health and welfare offices, with the primary goal of reaching people in their own neighborhood institutions and service organizations.

A longer-range implementation goal of the program may very well be the provision of the skills and manpower required for the organization of a national network for educating and supporting family caregivers while at the same time avoiding the bureaucratization and mediocrity which characterize so many of our large-scale programs. The emphasis would be on neighborhood/community initiative rather than on standardized national formulas. The strength of this concept rests on the provision of assistance to families which is sufficiently elastic in its ability to meet needs on a differential basis — groups, neighborhoods, communities — and which encourages the active participation of citizens' groups in the solutions to their problems rather than their remaining passive recipients of formalized services. It is predicted that the provision of such educational and supportive services to the family, enabling it to care for its older members, will become an increasingly im-

portant mode of formal network assistance,<sup>16</sup> and will quite likely represent that outreach to the informal caregiving network which is only now beginning to be developed.

#### Evaluation

As service providers and family caregivers begin to make use of such a program a number of questions will need to be addressed, especially in conjunction with the systematic evaluation of such a project, most specifically with respect to its effects upon caregivers, care receivers, and professionals as well. Do all caregivers need such communal outreach? For whom is such an intervention appropriate; for whom not? What other modes of outreach may be more appropriate to caregivers with specific needs, problems, or background characteristics? What effects might such groups have upon public and professional awareness of long-term care needs and responsibilities? What are the short-term and long-term residual effects on participants in such groups?

At least with respect to short-term effects, the continuous evaluation by both sponsoring organizations of the participants in both groups and the careful viewing and content logging of over 35 hours of videotape give every indication that an integrated educational-supportive outreach effort has either directly or indirectly contributed to changes in caregiving relationships, as well as to changes in the perception of caregiving roles and limitations. Perhaps the meaning of the group experience was summed up best by one member: "one of the things that you feel in a group like this is that there is no shame in your personal situation . . . we talked about things here that we could not share with our own families." Similar to their American counterparts, many members voiced the need for open-ended

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16. Kahana and Kahana, *op. cit.*

support groups with which they could affiliate on a long-term basis.

#### A CLOSING NOTE

Robert L. Kane,<sup>17</sup> writing on the topic of community medicine, notes that "it is ironic that a profession which began in the community should suddenly need to rediscover it." The same is unfortunately true of social welfare. After several decades of "experimenting" with centralized bureaucratic structures for the delivery of health, welfare, and educational services, it is perhaps time in Israel that the concept of "neighborhood networks" began to play a greater role in the lives of its citizens, if for no other purpose than to reduce or eliminate the social phenomenon of human alienation. In many Western nations citizen participation and involvement have long been characteristic of communal life. At least one traditional social work position assumes that participation is the quintessence of social work practice.<sup>18</sup> The issue of dynamically and innovatively involving people in the search for solutions to their individual and group problems on the neighborhood or community level is especially relevant in Israel today, where many are reaching the sobering conclusion that ". . . if I do not help myself, who will help me?"

An aggressively pursued, educationally and supportively grounded outreach effort to and with family caregiver groups may be one among many approaches to meeting old needs within the context of new social realities. In reaching out both to educate families as well as to cultivate them as equal partners in the community care of the chronically ill and dependent aged, groups such as these may provide one avenue, one means to the increased self-determination and involvement of citizens in their local health and welfare networks.

From an experiential perspective, videotaped caregivers, through their articulation of personal and collective problems, issues and concerns, may ultimately prove to be at least as effective as human services professionals in helping their peers deal with the personal, familial and social difficulties attendant to the caregiving role. Furthermore, through the medium of video, they may well have a vital role to play in the education and training of students and human services professionals. As Litwin<sup>19</sup> has pointed out, a video intervention, potentially reaching a geographically and culturally diffuse population, may facilitate a new kind of networking: a "grass roots movement"<sup>20</sup> out of which new services or service arrangements can evolve.

17. Robert L. Kane, "Community Medicine: What's in a Name?", in Robert L. Kane (ed.), *The Challenges of Community Medicine*. New York: Springer Publishing Co., 1974. pp. 3

18. Eugene Litwak, "Agency and Family Linkages in Providing Neighborhood Services," in Thursz and Vigilante (eds.), *op. cit.*, pp. 59-94.

19. Howard Litwin, "Video Work in Community Organization: Boon or Boondoggle?" *Community Development Journal*. Vol. 19, No. 3, 1984.

20. David Macarov, "Service Delivery at the Neighborhood Level in Israel," in Thursz and Vigilante, *op. cit.*, pp. 115-123.