

With approximately half of people over 85 facing some form of dementia, it behooves all of us to educate ourselves about it. In this special supplement, *N'shei Chabad Newsletter* presents insights, tools and stories on living with dementia. If you have found something that worked in helping yourself or a loved one with dementia, please write to us about it. We will be happy to share with our readers – Editors

My Grandfather:

Living Only in the Present

Rachel Spangenthal

Sometimes things just don't go as I had hoped. At the end of a day like that, I fall into bed hoping that tomorrow will be a brighter day.

But for my grandfather – the happiest human being that I have had the privilege to meet – life is different.

He always smiles when I visit him. He gives me a surprised, "Hello, Rebecca! I haven't seen you in a while!" and reciprocates my hug.

"No, Grandpa Eli, it's Rachel."

I sit down. Our eyes meet. He laughs.

"Where are you in life now?" he asks.

I give some response and he invariably replies, "That's lovely."

The conversation continues. His tone rises and falls. My focus is again drawn to the mosaic of veins and bruises upon his skin when he asks, "So, where are you in life now?"

I repeat what I have just said and offer to take him for a drive. An offer he gladly accepts.

We get in the car. His head tilts in curiosity and he says,

"Rebecca, it has been so long! Where are you in life now?"

I stop telling him I am not Rebecca, and tell him where I am in life now. He is delighted with my reply and gazes at the passing scenery.

"The day is perfect, isn't it? The weather is beautiful. Look at the sky!"

"Yes, Grandpa, it is. It is perfect."

The day is cloudy. He only sees sunshine.

He places his hand gently on mine. His eyes light up as a question occurs to him. "So, my darling, tell me – where are you in life now?" For my grandfather, every moment is created anew. It is tied neither to the last minute nor the moment following. He lives in an everlasting present – surrounded by the potential to begin afresh – and is delighted there.

We are taught that G-d speaks the world into being at every moment. Our lives, though they may seem to run independently of external forces, are nothing but a constant pulsating flow of G-dly energy. In a similar manner, a ball thrown into the air appears to rise of its own accord. Physics, however, dictates that the ball is only enabled to rise as long as the force from one's hand continues driving it upward. As soon as that force is exhausted, the ball falls to the ground. So, too, an ebb and flow of Divine light creates and recreates the world numerous times per second. We don't see it, but perhaps my grandfather does.

Perhaps my grandfather is not, as the rest of the world tells me, "losing it." Perhaps he is just more in tune with the reality of the world. A reality in which what matters is not from where you have come, but the endless potential in this very moment.

My grandfather exists in a world where one is never stuck in the mire of the situation; one need not wait for tomorrow to have a better day. Rather, from one second to the next, one can take a deep breath and begin again.

From my grandfather, I have learned that although life may become extremely challenging, I can always close my eyes, smile, and ask myself, "So, where are you in life now?" •

Help, Information and Support for Families of People With Dementia

The following information was compiled from interviews with medical professionals, and books and websites on the topics of dementia and Alzheimer's Disease.

WHAT IS DEMENTIA, AND HOW DOES IT DIFFER FROM ALZHEIMER'S?

People often mistakenly use the words dementia and Alzheimer's interchangeably. The word dementia actually stems from the Latin word "demens," meaning "out of the mind." Unlike Alzheimer's, dementia is not a disease but a description of a number of progressive symptoms. It is a general term ascribed to anyone whose mind is functioning at lower than normal levels to the point where one's mind and behaviors are noticeably and negatively affected

Although Alzheimer's is the cause of approximately 60% of dementia cases, there are many other causes. In other words, those with Alzheimer's always have dementia, but dementia patients do not always have Alzheimer's.

Contrary to what some people may think, dementia is not a less severe problem, with AD being a more severe problem. There is not a continuum with dementia on one side and AD at the extreme. Rather, there can be early or mild stages of AD, which then progress to moderate and severe stages of the disease.

Dementia is like fever – a symptom. Every fever doesn't prove infection, just as every case of dementia is not necessarily AD.

WHEN WAS AD DISCOVERED AND WHY ARE THERE SO MANY MORE CASES NOW THAN THERE USED TO BE?

Alzheimer's was first discovered in 1907, but the disease was not well known until the late 1970's. Since then, Alzheimer's appears to affect a rising number of people every year. One reason for this is simply that the risk of developing Alzheimer's increases as a person ages. People are now living longer than they used to. For example, in the past 100 years, life expectancy for a woman has increased from 53 to 81. Together with the increasing life span comes a greater number of Alzheimer's cases. Secondly, symptoms such as forgetfulness and loss of cognitive ability were, in the past, called "senility" and considered a natural part of aging. Thus, Alzheimer's and other forms of dementia were rarely diagnosed. Since then, technological tests such as CT scans and MRIs have helped differentiate between normal aging and things like dementia and Alzheimer's.

WHAT IS ALZHEIMER'S DISEASE?

Alzheimer's Disease (AD) is a brain disorder that today's population is, unfortunately, all too familiar with. It appears as a progression of symptoms that begin with a loss of ability to create and retain recent memories. A person in the beginning stages of Alzheimer's has trouble remembering his zip code, where he put his keys or what day of the week it is. Because these indications often appear slowly, Alzheimer's is frequently not noticed or diagnosed until five to ten years after symptoms begin. As the disease progresses, long-term memories such as names of loved ones begin to decay. Eventually, one with Alzheimer's exhibits a loss of orientation to person, place and time. In addition to memory loss, those with Alzheimer's may undergo changes in personality or social skills and have difficulty with language ability, perception, and cognition.

WOULD MUSIC BE HELPFUL TO MY RELATIVE WITH DEMENTIA?

According to writer and researcher Allison Takeda and author Michael Krauthamer [see Recommended Reading, below], who has worked with Alzheimer's patients with great success for several decades and in several different venues, music is a powerful catalyst for healing and unlocking memories in patients previously thought lost to dementia. One study out of France found that it reduces symptoms of anxiety and depression in people with Alzheimer's, and other research suggests that it facilitates cognitive function and triggers associations with events or emotions from the past."There's something about music that cuts through right up until the very end of the disease," Geri Hall, a clinical nurse specialist at the Banner Alzheimer's Institute in Phoenix, told ABC News. "It calms them, it increases socialization, and it decreases the need for mood-controlling medications."

Michael Krauthamer advises families of those with AD, "Please play some favorite music from his past and see if you can make a connection. Music can be extremely powerful with dementia patients."

Some families have found that hearing the tunes sung live by loved ones is even better than hearing them from the original artists. Very simply, hearing the right niggunim or songs can make sad people happy, even bring "sleeping" people "to life," without side effects.

WHAT CAN BE DONE FOR PEOPLE WITH THESE DISEASES, THEIR FAMILIES, AND THEIR CAREGIVERS?

Pharmaceutical research has produced a few drugs that purportedly help stave off symptoms of AD, but are still unable to stop the progression of the disease. These drugs may or may not provide some symptomatic relief for patients by helping improve mental functions such as memory, attention and language abilities, but they often cause negative side effects.

In some cases, the drug itself causes the very problems it is supposed to ameliorate. Here is a partial list of side effects from some common Alzheimer's drugs that were approved for use in elderly people with dementia: poor vision; loss of balance; dizziness; falls; incontinence; nervousness; agitation; increased confusion; insomnia; depression; abnormal dreams; delusions; irritability; aggression; restlessness; abnormal crying; hostility; emotional withdrawal.

In addition to memory loss, Alzheimer's patients commonly suffer from anxiety, depression, and agitation. A person who cares for a relative with Alzheimer's or dementia can assist the patient with a comprehensive approach of good medical care, mental stimulation, and warmth. Studies have shown that AD patients with female caregivers show greater life satisfaction than patients with male caregivers. This could be because women have a natural motherly instinct and treat the person who has dementia with an extra dose of patience, love and concern.

Caring for a loved one whose own mind is playing tricks on him is an emotionally demanding task and a physically demanding one as well. As vital as it is to remember to treat the patient with care, it is also imperative for extended family and friends to act towards caregivers with kindness and respect. Caregivers, especially the unpaid variety, need our moral support and respect. Most of all, they need our help, our visits, and the chance to regularly take time off.

WHERE CAN FRUM PEOPLE GO FOR ADVICE AND SUPPORT IN CARING FOR A RELATIVE WITH AD?

The frum communities in Brooklyn, New York, are blessed with the hard work and expertise of a woman named Muriel Mehlman. Calmly, lovingly, and expertly, Muriel Mehlman, MSW, leads effective support groups in Boro Park, Williamsburg, and Flatbush for people who are caring for incapacitated relatives. As one woman said on her way out, "This meeting is a lifesaver. When I come here, I don't feel like beating up my mother when I get home. I get strength and I remember that it's not his fault."

Muriel Mehlman told the *N'shei Chabad Newsletter,* "For many the responsibility of caregiving is overwhelming. The women find themselves angry, frustrated, resentful, depressed, lonely and alone. Our support groups provide a safe haven where they can vent and discuss problems with others who are living in similar situations. I have been given this opportunity to help these caregivers help themselves. Our support groups are titled **'A Time to Share, a Way to Cope'** because through group dynamics at our group sessions, the family members-turned-caregivers share their issues and help one another to cope in a healthy way."

For locations and times, and for any other questions, Muriel may be contacted at murielmehlman@yahoo.com or at 516.316.8890. No matter where you live, you can find the information and support you need. The Alzheimer's Association can direct you to resources in your city. Call 1.800.272.3900 or visit alz.org. Be'ezras Hashem, may we merit only revealed good and the ultimate Redemption when all the sick will be healed.



If you are caring for a loved one who is ill, don't go it alone. Join a support group. If you live in Brooklyn, there are several support groups specifically for frum women, expertly facilitated by Muriel Mehlman [above]. Call her for details at 516.316.8890.



Mr. Ely Hyman of Charlotte, North Carolina
(Rachel Spangenthal's grandfather)

STILL ALICE BY LISA GENOVA

This unusual book is written from the point of view of the actual person with Alzheimer's, not by relatives, caregivers or doctors, and it gives the reader a whole new perspective – the patient's. As the author, Lisa Genova, writes about *Still Alice*, "[One of my favorite scenes from the book] is a small scene with Alice [age 50, with early onset Alzheimer's] and her three [adult] children. The kids are all arguing over whether their mother should be trying to remember something or not. Alice asks what time they'll be going to a play the next day. Her son tells her not to worry about it, she doesn't need [to struggle] to remember something she doesn't have to because they're not going to go without her. Her oldest daughter thinks she should be exercising her memory whenever possible, the 'use it or lose it' philosophy. The youngest thinks they should just let their mom know the information, and she can do with it what she wants. This is pretty common in families where someone has Alzheimer's. There's disagreement and people dig in their heels and take things personally. It's rife with conflict. In this scene, they argue and hurt one another's feelings and never agree, all in front of Alice. People talk about people with Alzheimer's all the time right in front of them, as if they're not there."

"At some point, I will no longer experience the pain of watching my mind deteriorate to a point of incomprehension. Then the loved ones around me will have the unwelcome task to look after me and shelter me from harm. My burden is slight compared to that of the truly living."

–Thomas DeBaggio, in his book, "Losing My Mind: An Intimate Look at Life With Alzheimer's."

RECOMMENDED READING

Some families of people with dementia have found the following three books especially helpful:

THE 36-HOUR DAY BY NANCY MACE AND PETER RABINS

This little book is packed with sympathetic and friendly advice, and the detailed sub-titles are very helpful in quickly finding exactly what you want.

WALKING IN THEIR SHOES BY MICHAEL KRAUTHAMER

Michael Krauthamer is a medical professional who has run Alzheimer's wards. He is intimately familiar with the way his patients' minds work, or don't. His challenge is training the staff who work under him not to argue with the patients but to accept what they are saying since that is their reality at the moment. He utilizes the sociological model of healthcare (person-centered care) and Validation Therapy, which is a form of therapy discovered and developed by Naomi Feil. Through this he found that meaningful communication could be achieved with persons who were previously believed to be non-communicative, and negative behaviors could be redirected, diminished, or eliminated. The use of antipsychotic medicine and sedatives was also reduced or eliminated.

If you are going to buy one book on this topic it should be *Walking In Their Shoes* by Michael Krauthamer. Excerpts from this book may be found on the following pages. Michael Krauthamer may be reached at walkingintheirshoes@gmail.com. His website is http://walking-in-their-shoes.com.



Michael Krauthamer
Excerpted from the book with written permission of the author.

WALKING IN THEIR SHOES

HAROLD

Harold, a frail, gray haired 94-year-old, was sitting in his wheelchair glaring at me as I proceeded down the hallway and into my new office. Due to his frail condition, Harold was at risk for falling; therefore, he had a pull-tab alarm connected to him and his wheelchair to notify staff if he tried to stand.

One day, sitting in my office, I heard a loud commotion in the hallway as a high-pitched alarm blared. I immediately ran to the location, where I found Harold and a staff member in a heated argument, screaming over the blaring alarm. The staff member was yelling, "Sit down, Harold!" as Harold was yelling, "I don't have to!" It was apparent that neither person was going to win the argument or stop yelling. Finally, a nurse arrived and intervened. In a calm voice, she changed the subject and persuaded Harold to sit down.

At this point, it is important to discuss a major rule of communication. Never argue with a person who is diagnosed with Alzheimer's disease. In addition to creating hostility, it can invoke many more emotions, from sadness and loneliness to confusion. Even if they cannot understand your words, they do understand your nonverbal communication and tone of voice. Sometimes they even mirror it. Therefore, it is important that as friends, family or healthcare providers, we monitor our own behavior such as mood, tone of voice, attitude, and mannerisms, especially with those who have lost verbal communication skills or speak in a nonsensical manner. Sometimes they no longer comprehend the spoken word, so it is imperative to enhance communication through nonverbal means.

After reading Harold's psychosocial history and learning more about him, I gained much insight into his previous life. He had been a very successful farmer, raising both crops and animals. Although Harold had lived in the facility for more than one year, it was quite clear that he still believed that he was living on his 950-acre farm. Nevertheless, whatever Harold believed was his truth, *his reality*, and nothing anyone said could change his mind.

With the information obtained from his social history and a better understanding, I had a meeting with the staff and suggested that when Harold stood up, instead of yelling at him to sit down, they should walk over and ask in a calm voice, "Harold, where are you going?" After my request, a very long time passed before I would hear his alarm sound again. When it did, I looked up and sure enough, he was trying to stand. He was in such a fragile physical state that he couldn't stand, let alone walk. My concern was that he would fall and hurt himself. As the alarm sounded, I ran to him in the hallway. In a calm voice, while making eye contact, I said, "Hey Harold, where ya goin'?"

Harold's stone-cold eyes glared into mine as he stated, "I am goin' to feed my animals."

Trying to think fast, I said, "Harold, I just fed your animals."

With some confusion showing on his face, he said, "You did?"

"Yes, Harold, I just walked back in. It sure is cold out there."

With that statement, he slowly sat back down as the alarm stopped sounding. Wow, my first experience with validation therapy and it worked! Harold

was happy that his animals had been fed and I was happy that he was sitting down.

...One day, while walking down the hallway, I heard someone yelling and cursing inside his room. As I knocked on the door and entered, Harold was partially sitting up in his bed, leaning on his elbows and yelling, "Who told those [expletive deleted] they could drive on my property?" Harold was hearing and seeing the traffic on the street outside the window. His question caught me off guard and I blurted out, "Well, Harold, they put a road on your property."

Harold snapped back, "I didn't give anybody permission to put a road on my property! Who did it? I hope they paid me good money to put a road there."

At that point, the only words that came to my mind were that it was the government and they had a lot of money and needed to put the road there so people could make it to the other side. With that explanation, Harold calmed down and resumed his nap. Validating that Harold owned the property and using a therapeutic fib stating that he was paid good money for the road was successful.

Harold snapped back, "I didn't give anybody permission to put a road on my property! Who did it?"

JUANITA

Juanita, a tall, stately, slender woman who walked with a cane and slight limp, had retired from nursing. This quiet yet dignified woman was diagnosed with Alzheimer's disease combined with audiovisual hallucinations. Some days, she believed that she still worked as a nurse. Often in Juanita's mind, her dog, Peppy, was by her side. Although Juanita was the only person who saw or heard Peppy, he was very real to her. He lived in *her reality*.

One day, while working in my office, I overheard loud voices at the nurse's station. Juanita, in an angry voice, yelled, "Peppy told me that you owe me $20 from that check I gave you!"

Of course, no check had been written and no money was owed, but I listened further.

"I don't owe you any money and you didn't give me a check!" the nurse shouted.

"Yes, you do, Peppy was watching you and he doesn't lie. You do owe me another $20!" Juanita said.

At this time, a shouting match ensued and I overheard the nurse tell another staff member to go and find another nurse to assist her in giving Juanita a shot containing a prescribed medication only to be given if needed for medical reasons or, in this case, a "behavior."

When I heard the nurse instruct the staff member, I jumped up from my desk, grabbed a legal pad and immediately ran out of my office to find the nurse and resident continuing their heated argument. Politely, in a calm tone, I interrupted, "Miss Juanita, I heard that someone owes you some money and I am here to do an investigation. Can we sit over here so I can get some information?" Juanita looked at me with relief and said, "Yes, I would appreciate your help."

As we sat down, she continued, "Peppy said that woman behind the desk didn't give me all my money and she still owes me $20." Of course, there was no Peppy, but she believed that he was sitting beside her and she could see him. When she brought up Peppy, I said, "You know, I don't know very much about dogs. What kind of dog is Peppy?"

She was happy to reply that Peppy was a male poodle and that her mother and father had bred poodles when she was growing up. She continued telling me that she had always loved animals, but poodles were her favorite by far. At this point, Juanita had completely forgotten the argument over $20 when two nurses approached her with a syringe.

"Juanita, can you come in here so we can talk to you?" The nurses wanted her to go in the shower room so they could give her a powerful medication to reduce her "behavior."

"What do you want to talk to me about?" asked Juanita.

"You know... the money I owe you," replied the nurse.

Juanita did not need a shot at any point. She had forgotten the $20. But the nurses convinced her to go with them into the shower room. Without success, I strongly voiced my concerns to the nurses, trying to explain that the medication was no longer needed. The nurse proceeded with her plan. For the rest of the day, Juanita sat slumped over in a cloudy haze from the medication she had been given.

Although it is sometimes a necessity, I do not believe in medicating persons for being confused, and always believe we should try to resolve the situation through verbal and nonverbal communication. In addition, at least three attempts should be made at communication before any medication is even considered. Sick people have the right to be free from physical and chemical restraints unless they are a danger to themselves or others. In this case, the nurse, a healthcare professional, had antagonized the resident to the point of great anger. This was unacceptable behavior by the nurse.

MIRRORING

...It is important that everyone with Alzheimer's disease do as much for themselves as possible so they don't forget. Therefore, if someone needs guidance but can still continue to get up and get dressed but only with assistance, it is important to gently guide them, by saying, for example, "Would you like to wear this, or this?" Depending on cognitive deficit, a general rule is to give no more than two choices. Many times, if someone doesn't understand how to button their sweater, the staff or family member can button their own sweater and ask the person to mirror what they are doing, or if they cannot brush their hair, then a staff member can brush their own hair as the person holds a brush and ask them to do the same activity.

Some people pick up these tasks quickly while others cannot. It is important to never force anyone to do anything they do not want to do. If you can see that the person simply cannot button their sweater or brush their hair, you should stop. If you continue to insist, you will create a problem situation.





Michael Krauthamer at work.

Maintaining the stage of activity is important but forcing someone to do something they can no longer remember how to do can create sadness, confusion and anger. Observing nonverbal communication is always important.

DAVID

David had moderate cognitive impairment, and a problem with his short-term memory. In fact, after he finished his meals, he would inevitably go to his room and return five minutes later and ask, "Is it time to eat?" David was fun-loving and always smiling and telling jokes until he felt someone was in trouble; then he would want to go to their defense.



Every day, David offered one or more residents a ride in his van that he believed was parked in the parking lot. He would often ask me if I could show him how to get to the parking lot.

I would explain to David that his van was being worked on and I was waiting for the mechanic to call me when it was finished. Sometimes he would ask what was wrong with the van, and other days he would just say, "Well, come and get me when they call." David was always easily redirected when discussing his van and continued to offer rides to many of the residents.

He had a heart of gold and had lived in the same room for five years. Because he enjoyed socializing, his room was by the main dining room and activity area. Due to his extreme confusion and short-term memory deficit, I felt it was important that he never be moved to a different room. He had great difficulty processing information and I knew a move would totally disrupt his life. This belief was made known to the administrator.

One day my administrator came to me and said he wanted to give David's room to a new resident. To make matters worse, he wanted us to move David immediately. As the administrator stood over the charge nurse and me, waiting for us to make the telephone call to the responsible family member, both of us were shocked and in disbelief that he would order this change; we knew what the future would bring. The nurse made the call to the family member and instead of requesting permission, the administrator ordered us to tell the responsible party that we had to move David. Despite protest and confusion by the family member, we moved David.

In the state where I work, it is illegal (and everywhere it is unethical) to move residents from room to room without justification. Once a "patient" is moved into a long-term healthcare facility they become a "resident." The institution becomes the residence, and there are specific rights implemented by the law to ensure adequate care is given and no civil or federal laws are broken. In all states, there are "Residents' Rights." If you have a relative in an institution, please check with your local State Department of Health to obtain a copy. In my state, there must be a medical or psychosocial need, and permission must be granted in advance by a person responsible for the resident's care, such as a family member with power of attorney, or guardian.

The administrator had ordered us to move him four doors away from where he currently lived. I placed a big sign with his name on the door and the nurse and I placed all his belongings in the same location as his previous room, hanging pictures and placing knick-knacks in the hope that he would feel at home. But this plan was unsuccessful.

From the very beginning, the room change was a nightmare not only for David, but also the staff. For two weeks he continued to go into his old room and was redirected by staff many times per day. He was so confused. Some days, he would ask for a ride to his home, and other days he believed that he was on the wrong floor of his previous apartment building and asked us how to get to the 12th

floor. Sometimes, he would become agitated when the staff redirected him to his new room, and other times he just appeared confused. After all, he had lived in his old room for five years, which was an eternity for David.

As the weeks turned into a month, David was not getting any better. We had a psychiatric evaluation performed and his medications were increased, to no avail. He was becoming more and more confused about everything and now, easily agitated. His nonverbal communication now revealed depression. He had attended many activities in the past, but after his room change, he would remain inside until meal times and refused many activities; he was no longer interested.

One day after his old room became vacant and the administrator was not present, the nurse and I worked at record speed to call his responsible party and move David back to his original room. After several days, he was back to his regular self.

To this happy-go-lucky resident, something as small as a room change was detrimental. He was affected in a very strong, negative manner. The staff working with him were also affected by the negative change in his personality. Although he was back to his regular self, the experience confirms that someone as confused as David should never be moved except in rare cases when special circumstances absolutly require it.

CONCLUSION

Remember, no one really knows how much someone at this level comprehends. Therefore, you should never talk about the person in front of them. I remember a sister who visited frequently but was always trying to force the resident to "act right," and would say things such as, "Stop mumbling. I know you can talk better than that. Stop it! You know my name. Now, what is it?"

I suggest that when greeting a loved one, say, "Hi, this is your son John. How are you today?" This way you can gauge where the person is. The person may say, "Well, I know you're my son John!" Great, then you know the person knows you. But if they show no recognition, drop it. I have witnessed much confusion and sadness while loved ones tried to explain, at great length, that the person has to know them.

I have witnessed much confusion and sadness while loved ones tried to explain, at great length, that the person has to know them.

I have had many discussions with residents' family and friends who were confused about whether their loved one knew who they were. Through my journey of observing nonverbal behavior among this select group of people, there is no doubt in my mind that most residents did know who the person was, or at least knew their visitor was someone significant in their life.

Sometimes it is not clear how the connection is made, whether through tone of voice, a familiar face, or comforting touch. Many residents exhibit nonverbal and sometimes nonsensical verbal behavior that demonstrates they have been touched by their visitor in a positive way: whether a smile, increased physical activity, verbalization, or other positive communication.

My mission is to spread the word on how easy it is to communicate in a positive manner. When these techniques are performed effectively, they assist you in understanding their form of communication.

Not only will this preserve dignity and respect of the person, but also bring you joy, due to the fact that you are communicating, just on a different level. So, if you ever feel challenged or confused by a loved one with Alzheimer's disease, I recommend that you take the time to walk in their shoes.•



I Write This **First Hand**

Chani Zirkind

There's not much to say,
At least at my age.
There's not much to do,
At least in my stage.

I'm frail and weak,
I can hardly talk.
Never mind sit,
Stand up or walk.

I need help to wash,
To move and to eat.
Caring for me
Is no easy feat.

I cannot articulate
In words how I feel.
The tiniest sound
Is such a big deal.

In a state such as mine.
They think I don't hear.
They think I don't know,
They think I don't care.

But really, each thing,
Each word people mention
Leaves on me
A lasting impression.

I know this is true,
I write this first hand.
I know you can't tell,
But I do understand.

I do feel the care
When they hold me tight,
And when they wake up
To help me in the night.

From my condition
I've learned one thing:
Give respect and devotion
To each human being.

They treated me
More precious than gold,
At my frail, weak age
Of just one day old.