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Spiritual Care in Israel

An Evaluation of the Programs Funded by the UJA-Federation of New York

Netta Bentur ◆ *Shirli Resnizky*

The study was funded by the UJA-Federation of New York

RR-526-09

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Jerusalem January 2009

Myers-JDC-Brookdale Institute
P.O.B. 3886
Jerusalem 91037, Israel

Tel: (02) 655-7400
Fax: (02) 561-2391

Web site: www.jdc.org.il/brookdale

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Executive Summary

I. Background and Study Goals

In early 2006, the UJA-Federation of New York launched a major new funding initiative for the development and provision of spiritual care services and training programs in Israel. Prior to this initiative, the field of spiritual care was virtually unknown in Israel; no training programs were being offered and there were no formal frameworks offering services, with the exception of very limited and sporadic efforts. The 2006 initiative was a result of an earlier initiative by the Federation of to explore the potential to develop the field of Jewish spiritual care in Israel. The Federation recognized the value of incorporating spiritual care into the work they were already supporting in Israel among vulnerable populations, such as the elderly and those facing illness, trauma and bereavement, in order to provide a more comprehensive and holistic response, similar to the work supported in New York.

The aim of this report is twofold: First, to provide an in-depth, systematic overview of the current status of implementation of spiritual care programs and their development over the last three years; and second, to explore the short- and long-term future needs and directions of this new discipline and to identify current opportunities and challenges in order to better plan and promote spiritual care in Israel.

The word "spiritual" derives from the Latin *spiritus*, meaning breath, and can be interpreted as pertaining to the non-physical or metaphysical and sometimes having a bearing on moral, psychological and religious aspects of life. Some define spirituality as the "ultimate meaning and purpose of life" (Puchalski et al., 2000). Spiritual care is necessary because everyone, whether religious or not, needs support systems, especially in times of crisis. Spiritual care is about supporting individuals and helping them maintain their personal identity in a threatening situation. Its purpose is to create hope in situations of distress and loss and to produce meaningful relationships and experiences. This is particularly apparent in medical settings that usually disregard these existential components of illness and focus only on its physical aspects. Spiritual care in the medical context is provided to people with serious illnesses. Its goal is to help sick people achieve moments of peacefulness and acceptance, while contending with illness and facing death (B'Ruach, 2009). Spiritual care (or chaplaincy, as it is known in the USA and Canada) is a completely person-centered form of care; it makes no assumptions about personal convictions or life orientation and is not necessarily religiously oriented.

II. The Study Design and Description of the Report

In this study, we conducted over 80 in-depth interviews with persons involved in the development of spiritual care in Israel, including:

- Directors of training and service programs
- Leading proponents of spiritual care services
- Senior directors and stakeholders at government ministries, hospitals, nursing institutions, and voluntary organizations

- Students and graduates of spiritual care educational programs
- Patients and family members who have received spiritual care services

We also held substantial and intensive discussions with senior executives of Jewish chaplaincy and healing movements from the United States during conferences in Israel and in the US.

The report is divided into seven sections, each describing the achievements of a different aspect of spiritual care in Israel and presenting the main issues and challenges facing them. The first provides the background, drawing upon experiences in the US and Europe, and describes the context in which this new discipline has developed in Israel. The second and third sections describe the training programs and analyze feedback from students and graduates. The fourth describes the programs providing services to patients and caregivers, while the fifth presents feedback from recipients of spiritual care and attempts to explore pertinent themes. The sixth section discusses the future development of the profession in Israel from the perspective of policymakers and stakeholders. The concluding section focuses on future challenges and appropriate directions for spiritual care in Israel.

III. Summary of Findings

a. Spiritual Care Training Programs

Altogether, nine programs currently provide spiritual care training courses. Three of them offer intensive training courses for individuals aspiring to become professional spiritual care providers (*tomech ruchani),* five provide in-service training and education in spiritual care for health and social service professionals, and one offers short in-service training to health professionals and the general public, as well as conferences, retreats, and seminars.

In the three years since the programs were initiated, they have accomplished the following:

- 60 spiritual care providers have been trained
- 350 rabbis, community leaders, educators, and medical/mental-health professionals have received in-service training
- 4,000 professionals have been introduced to this new discipline at seminars, conferences, and workshops.

The directors and senior staff of the training programs invest huge efforts and resources in developing the general public's understanding of spiritual care and in explaining the essence and goals of spiritual support and its potential contribution to physical and mental health. One of the main challenges for these programs stems from the acute shortage of credentialed spiritual care providers and trainers, which substantially reduces the capacity of these programs to offer courses that focus more precisely on the principles of spiritual care.

The interviews with students and graduates reveal that the programs are successfully achieving their goal of training spiritual care providers. The respondents reported that they had professionalized and had acquired a comprehensive range of tools to help them in their work and

enhance their understanding of their position. The students expressed great appreciation of their facilitators as teachers and as human beings and considered them to be important role models. They said that the challenge facing them was how to best incorporate spiritual care into the hospital and social service systems in Israel. Placing the students in jobs is a very important matter but the profession is not well known and there are few paid positions for spiritual care providers in the country. Therefore, enormous effort and human resources are currently invested in placing the students and supporting the graduates. These – evidently essential – efforts are demanding, but ultimately they contribute significantly to successful placement opportunities. Even though the facilitators attempt to prepare the staff in the field, some respondents reported they encountered ambivalence. However, graduates who are already working as spiritual care providers reported a sense of security at their places of work and said they enjoyed full cooperation from other members of staff. Graduates not currently working in the field expressed confidence in their ability to provide care to patients, but were concerned about limited paid job opportunities.

b. Programs Providing Spiritual Care Services

The UJA-Federation of New York currently funds spiritual care programs at eight organizations, through which nearly 7,000 individuals have participated or received services at least once in the past three years. The organizations have contributed hugely to raising public awareness of the value usefulness of spiritual care. Among the beneficiaries of the support are cancer patients, diabetics, people with terminal and/or chronic illness and their families, the elderly, victims of terrorist attacks, and individuals facing acute, existential problems such as transition issues, bereavement, and loss.

One challenge facing proponents of spiritual care stems from the fact that the organizations vary greatly in terms of whether they work in the community or institutional settings and whether they implement tailor-made spiritual care programs or have taken "ready-made" programs and incorporated the principles of spiritual care into them. This variation often produces inconsistencies in the definition of spiritual care and the challenge is to develop a standardized definition and terminology for spiritual care, which would be an important asset in the promotion of spiritual care to ensure its acceptance by the Israel health and social systems.

All the organizations strive to reach the broadest possible population and increase participation in their programs. They use an assortment of tools to disseminate and advertise their spiritual care activities and express a strong desire to improve and expand programs. All the respondents emphasized the acute shortage of spiritual care providers, which limits development of the discipline in Israel considerably. In addition, many directors are constrained by limited budgets and invest much of their time attempting to raise funds for the continuation of their services.

We interviewed 14 patients and/or members of their families, who were representative of a broad cross-section of Israeli society. They expressed powerful themes, including:

- The uniqueness and importance of spiritual care in a health environment often perceived as threatening and cold
- The light the spiritual care provider brings into their lives, in the context of illness, death, and loss
- The spiritual care provider's ability to engage with them in the discussion of difficult subjects
- The spiritual care providers' ability to focus on each person as an individual
- The spiritual care provider's ability to empower and/or advocate for the patient

c. Attitudes of Stakeholders and Policymakers toward Spiritual Care

In order to better understand the challenges facing the development of spiritual care in Israel, we conducted 15 interviews with a broad range of policymakers and stakeholders. These include hospital directors, nursing home directors and executives in the health and social system.

The main themes and issues raised by the hospital directors included:

- They received superlative feedback from patients, their families, and members of staff about the contribution, seriousness, and professionalism of the spiritual care providers, making them realize that spiritual care is "something special"
- They consider the promotion and integration of spiritual care to be a positive – and inevitable – development in the Israeli health and social service systems
- The UJA-Federation of New York funding for the initial implementation of spiritual care services in the hospital system has been crucial
- Concerns was expressed about future funding, especially by those who wish to expand spiritual care activities to other departments at their hospital

Aside from the hospital directors, however, most of the stakeholders and policymakers are unfamiliar with spiritual care. They have little knowledge of the discipline and virtually no direct experience. These interviews brought to light many common themes and concerns:

- Lack of knowledge and understanding about spiritual care and confusion over the difference between spiritual and religious
- Concern about how health and social service professionals will relate to spiritual care providers
- It is a challenge to introduce new ideas and programs into Israel
- Concerns about funding and the competition for limited resources from other professionals

Most of the stakeholders and executives – whether familiar with spiritual care or not – believe that the discipline has to evolve gradually, starting with the service providers, i.e., a bottom-up approach. Once sufficient momentum has been achieved, the health and social service policymakers can become more fully involved. The respondents think that it is important to continue the current funding for programs of this kind and to use them as a catalyst to inspire greater interest within the wider community and recognition of the important role of spiritual care within the health and social services.

Another important issue raised was the accreditation and professionalization of the spiritual care providers. Stakeholders and policymakers feel that in order to fully integrate spiritual care into the health and social services, there needs to be professional training and official credentialing. All stressed the urgent need to take steps to ensure that spiritual care providers be included in the register of professions and given formal recognition in Israel. This would require a formal and professionally recognized training program that would be officially licensed in the same way as other paramedical professions.

IV. Future Directions for the Development of Spiritual Care in Israel

The report proposes a possible framework for the future development of spiritual care in Israel. Based on the interviews and our evaluation, it seems that there are two basic approaches to implementing spiritual care and integrating it more fully into Israel's social and healthcare systems:

- Consolidating and professionalizing the profession in Israel
- Broadening the scope of spiritual care, so that stakeholders become familiar and comfortable with the idea.

With the vital support of the UJA-Federation of New York, spiritual care is evidently being developed in Israel at the right time and suits the current Israeli zeitgeist and interest in the existential and spiritual dimensions of Judaism. The initial foray into spiritual care has introduced thousands of professionals and recipients to a virtually unknown field through individual care, conferences, seminars, and workshops.

Among the steps that could be considered for future development of spiritual care in Israel:

- Appointing a steering committee for the development of training programs for spiritual care in Israel whose members have the appropriate academic and professional credentials
- Designing a curriculum for the training of spiritual care providers that is suited to the Israeli culture and meets the academic standards required in other parts of the world
- Identifying one or more academic institutions in Israel recognized by the Council for Higher Education that will accept the curriculum
- Creating in one of the organizations a position for introducing spiritual care and for coordinating all these important developmental and organizational academic and training activities
- Developing and implementing placement system for spiritual care trainees and graduates and establishing spiritual care as a profession that is similar to other recognized allied medical health professions
- Developing a substantial, active cadre of spiritual care providers in Israel by providing training fellowships in the US, providing additional intensive CPE (clinical pastoral education) courses in Israel, and devising an accelerated individual training program for the few people currently involved in promoting the discipline in Israel. These may help increase the number of spiritual care providers in Israel in the short term

- Raising and promoting awareness of spiritual care by implementing model demonstration projects to facilitate broad exposure of the discipline, constitute a model for others, and serve as way of disseminating information about the role of the spiritual care provider. Once stakeholders have been introduced to the value of spiritual care, they will be more likely to find future funding for such programs. Without this initial experience, they are unlikely to fund such an innovative program
- Endeavoring to gain official recognition from various government agencies, which will allow spiritual care services to be provided within the health and social system. There is a need to develop a higher public profile and visibility in order to get professional recognition from the ministries, policymakers, and stakeholders. The most appropriate way for getting it is through grass-roots development of spiritual care (meaning bottom-up approach). This is about creating the need for spiritual care in the many services so that the various government agencies will have to formally recognize the field. It is unlikely that these government agencies will take the initiative on spiritual care until it is shown to be a useful part of the system.

V. Conclusions

Within a very short space of time, there has been a remarkable growth of spiritual care programs in Israel. In a little under three years, thousands of individuals, professionals, and recipients of care have been exposed to the discipline. With their knowledge and expertise, as well as their critical funding of numerous programs, the UJA-Federation of New York's Caring Commission, through the Health, Healing and Hospice Taskforce has been instrumental in the development of Jewish spiritual care in Israel. Their efforts included an initial survey of the field, identifying relevant agencies and cultivating leadership to develop the field, facilitating a shared learning and planning process, creating opportunities for Israelis to benefit from the New York/North American experience in collaboration with NAJC and the National Center for Jewish Healing and encouraging networking towards the development of an umbrella organization/coalition to advance the field.

Among the directors of programs and institutions, students and rabbinical trainees, and recipients of care, there is a genuine excitement about the potential value and impact of spiritual care and those currently involved believe that spiritual care is being implemented in an appropriate manner for the Israeli social context.

Spiritual care has begun to develop roots within the health and social services system in Israel, but it is still in its infancy. The implementation process needs to continue apace, with care and consideration given to the best way of gaining acceptance for spiritual care within the health and social services systems. In this report, we have set out some ideas and methods to continue the many achievements already made.

Spiritual care provides the potential for shared existential connections and meeting places among the sheer vibrancy and diversity of Israeli society. It needs to be an integral part of health

and social services. Many of those already involved in the implementation of spiritual care feel that the language of spiritual care needs to enter the health and social service culture of Israel, and that all individuals, irrespective of religious or cultural affiliation must be provided with a way to express their fears and hopes during times of illness and distress.

Acknowledgments

Numerous people gave us their help while we were conducting the study and writing the report and we wish to thank them all. First of all, we thank Elisheva Flamm-Oren of the Israel office of the UJA-Federation of New York for overseeing and supporting the program and the study, for her involvement, and for the many hours she devoted to discussions, to reading drafts, and providing us with her comments. We also thank Roberta Leiner and Sally Kaplan of the UJA-Federation of New York's Caring Commission, as well as Tina Price, Ann Yerman and Lois Perelson-Gross, that have been the chairs of the Health Healing and Hospice Task Force, for giving their support and recognizing the importance of the study and for their helpful comments on drafts of the report.

We express our heartfelt thanks to the directors of the spiritual care provision and training programs, who gave us their valuable time to deepen our understanding of spiritual care and what they are doing to develop this field. Thanks to the hospital directors, directors at the Ministry of Health and the Ministry of Social Affairs and Social Services, to the spiritual care providers, and to the patients and members of their family for their frank, meaningful, and profound discussions with us. Special thanks are due to Cecill Asekoff of the National Association of Jewish Chaplains, for the information and deep insight we gained from her, and for her infectious enthusiasm. We warmly thank Dr. Barry Kinzbrunner, executive vice-president of Vitas Innovative Hospice Care, for maintaining our longstanding relationship and for deepening our understanding.

We wish to thank Prof. Avi Israeli, Director General of the Ministry of Health, Miriam Bar Giora, of the Ministry of Social Affairs and Social Services, Yaakov Kavilo of ESHEL, Prof. Jonathan Halevy, Director General of the Sha'arei Zedek Hospital and Dr. Yehezkel Caine, Dirctor General of the Herzog Hospital for their cooperation during the study and their important contribution to our understating of the conditions and possibilities for developing the discipline in Israel.

We are grateful to all our colleagues at the Myers-JDC-Brookdale Institute who helped us in our work with their suggestions and insights, particularly to Abram Sterne, who helped edit and rewrite copious sections of the report. We are deeply grateful to Jenny Rosenfeld, chief editor at the Institute, for her original ideas and for adjusting the language to the Israeli culture. Finally, warm thanks to Naomi Halsted, for editing the report in English, to Elana Friedman for her typing, and to Leslie Klineman, for preparing the report for publication.

Table of Contents

List of Tables

1.Introduction to the Evaluation

1.1 Introduction and Study Goals

In 2004, UJA-Federation of New York began to explore the field of Jewish spiritual care in Israel and in 2006, it launched a major new initiative that included the funding of pioneering spiritual care services and training programs. Until that time, such services in Israel were virtually non-existent and activity was limited and sporadic. In June of 2007, the New York Federation commissioned the Myers-JDC-Brookdale Institute to conduct an evaluation study to ascertain the current status of spiritual care programs in Israel and to support future planning.

The report has two goals: First, to provide an in-depth, systematic overview of the current status of implementation of spiritual care programs, after initial funding had been received and they had been implemented for a limited period and show how the subject has developed over the last three years; and second, to explore the acute future needs and directions of spiritual care and to identify current opportunities and challenges for planning and promoting the field in Israel. This chapter describes the context in which spiritual care is being implemented in Israel.

1.2 Spiritual Care in the Modern Era

Spiritual Care and Medicine

The word "spiritual" derives from the Latin *spiritus*, meaning breath, and can be interpreted as pertaining to the non-physical or metaphysical and sometimes having a bearing on moral, psychological, and religious aspects of life. Some define spirituality as the "ultimate meaning and purpose of life" (Puchalski et al., 2000). In their comprehensive review, Mcsherry and Cash (2004) argue that linguists, philologists, social ideologists, anthropologists, researchers, and mystics may all offer different descriptions and interpretations of spirituality. They conclude that "the term 'spirituality' is problematic and in danger of becoming meaningless and a universal definition of spirituality may be theoretically and culturally impossible." Others argue that spirituality is an innate aspect of being human and, specifically, that it is possible for every individual to grow through the experience of illness (Okon, 2005).

Spiritual care in the medical context is provided to people with serious illnesses. Its goal is to help sick people achieve moments of peacefulness and acceptance, while contending with illness and facing death (B'Ruach, 2007). Spiritual care (or pastoral care, as it is sometimes known in the USA and Canada) is a completely person-centered form of care; it makes no assumptions about personal convictions or life orientation and is not necessarily religiously oriented.

Spiritual care is necessary because everyone, whether religious or not, needs support systems, especially in times of crisis. Clinical experience has revealed that spirituality plays a critical role in it, because the relationship with a transcendent being or concept can give meaning and purpose to people's lives, to their joys and to their suffering (Puchalski and Sandoval 2003). A number of studies have shown the importance of considering spirituality in the health care of patients and the relationship between patients' religious and spiritual lives and their experiences of illness and

disease (Levin and Schiller 1987, Levin at al. 1997, Cohen et al 1995, Puchalski, 2002). Thus, many patients, carers and staff, especially those confronting serious or life-threatening illness or injury, have spiritual needs and welcome spiritual care. They face ultimate questions of life and death. They search for meaning in the experience of illness. They look for help to cope with their illness and with suffering, loss, fear, loneliness, anxiety, uncertainty, impairment, despair, anger and guilt. They deal with the ethical dilemmas which advancing technology and heightened expectations generate at the beginning and end of life. They address in depth, perhaps for the first time, the realities of their human condition. Those actively associated with a faith community, may derive help and comfort from their religious faith and from the faith communities to which they belong. The beliefs and rituals of their religion and the ministry of its leaders and members are often sufficient to meet their spiritual needs. (Scottish Executive, 2002) On the other hand, the majority of the population today, have no such religious associations yet recognise their need for spiritual care, look for a skilled and sensitive professional, who has time to devote to them and to be with them.. A person who will acknowledge the deep desires and stirrings of their spirit, recognise the significance of their relationships, value them and take them seriously. They look for someone or something that can help them to find within themselves the resources to cope with their difficulties and the capacity to make positive use of their experience of illness and injury (Scottish Executive, 2002).

Spiritual care is about supporting individuals and helping them maintain their personal and spiritual identities, which are often threatened in healthcare and social service situations. It is a way to create hope and meaningful relationships and experiences in the context of medical care and the absence of talk about hope and meaning (Scottish Executive, 2002). Quality of life can be enhanced by an encounter with the spiritual dimension and can both shape and be shaped by beliefs in health and recovery from illness (Kaufman et al. 2007). Focusing on beliefs and hopes can often help individuals promote feelings of wellbeing that are either linked with improved outcomes to illness or a better response to end-of-life situations. (Flannely et al., 2004).

Spiritual Care and Religion

Spiritual care is about recognizing the value of individual beliefs, which are expressed in many forms. Its proponents believe that any person, regardless of whether or not he/she is religious, can benefit from spiritual support systems.

We live today in a pluralist society in which individual beliefs find expression in a multiplicity of forms. Religious belief and practice have also undergone a major reformation. Moreover, the majority of patients, carers and staff have no association with any religious group and therefore, spiritual care providers in healthcare settings now, have to devote most of their working time to people who have no link with any faith community, yet may well profess a belief in God or recognise they have spiritual needs while they are in hospital or another healthcare setting. Spirituality is broad in nature and unique from one individual to another. Each patient and family has his or her own understanding of meaning and purpose.

Providers can encourage religious and spiritual practices with their patients if these practices are already part of the patient's belief system. However, a nonreligious patient should not be told to engage in worship any more than a highly religious patient should be criticized for frequent church attendance (Post et al 2000, Lo et al. 2002). The spiritual care providers, or chaplains (who are not necessarily clergy, although they can be) know how to work with patients with different religious or spiritual beliefs. They can also work with atheists and agnostics.

Many health organizations today make a distinction between religious and spiritual care. While religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community, professional spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation. Spiritual care is not necessarily religious. Religious care, at its best, should always be spiritual.

Spiritual Care Providers and Other Health Professionals

Spiritual caregivers and religious leaders are not alone in offering pastoral and spiritual care. Ideally, it should be offered by other members of staff in the course of their professional work, by visiting relatives, significant others and friends. A compassionate spiritual orientation should be an integrate part of the therapeutic plans. Health care providers should strive to discuss these concerns in a respectful manner and as directed by the patient (Post et al 2000, Ruston et al. 2002).

However, during the routine every-day life, staff members often feel unskilled and uncomfortable discussing these concerns. Most do not devote their time and effort to the spiritual needs of the patients. For example, Holloway (2005) examined the development of social work practice in spiritual care and the attitudes towards spirituality and religion in the UK. In comparing findings from two studies, (one conducted in1990-1992 and the second in 2004), Holloway found that the increased sympathy towards 'spiritual practice' is not as great in social work as is demonstrated amongst other human services professions, and that there is continuing inhibition and resistance in the UK social work education. Since she believes that spiritual need and spiritual interventions might connect with social work's core business, she argued that much of the problem for social workers, even where they identify spiritual need as an issue, lies in inadequate guidance and lack of practice the context of social work; as well as lack of time. Wesley and her colleges (2004) also found, in a national survey in the US, that although spiritual care is shared among hospice team members and that most social workers feel comfortable in addressing these issues, role conflict and role ambiguity also exist. Social workers often felt ill-prepared to deal with some complex faith-based conflicts related to diversity. In another study, practitioners reported that although they believed that spiritual care is important to patients, they indicated barriers of time and training to implementing these beliefs (McCauley et al. 2005). Family physicians also affirm their role in responding to patients' spiritual concerns but they raise many barriers to achieving it. These include physicians' role definition, familiarity with factors likely to prompt spiritual questions, and recognition of principles guiding spiritual discussions (Ellis et al., 2002; Ellis and Campbell, 2004).

Thus, it seems that in today's health service we need the distinctive contribution of professionals who are trained in spiritual and religious care and have time to give it. It seems that the other professionals in the teams do not take on this role on a day-to-day basis.

Providers of spiritual care see health holistically from a typically distinct perspective from the traditional medical viewpoint. Where practitioners of medicine and health professionals see patients, problems, and treatments, the spiritual care provider sees unique individuals with aspirations, ideas, and personal themes of life.

Spiritual care provision is a profession that can work powerfully in concert with other medical and social professions and can function in various healthcare settings, including hospices, long-term care and geriatric hospitals, rehabilitation and intensive care units, and general hospitals (Flannely et al., 2004).

The Role of the Spiritual Care Provider

As already maintained, the spiritual aspect of human nature raises questions about ultimate meaning and purpose, questions for which medicine and science have no answers. These issues require a unique language in which symbolism, story, and ritual are often involved. Spiritual care providers have expertise in this form of communication and are often best able to answer such questions. Some of these questions and concerns might be stated in the language of faith or religion. In some instance statements of faith would be used to deal with these questions, and in other times, questions dealing with the purpose of one's life might be more appropriately answered in existential terms. The spiritual care provider can deal with these issues in terms of how the world works, spirituality, and what we consider the essence or meaning of life.

The main goal of a spiritual care provider, or chaplain, is to support the patient and to be emotionally present for him or her. This is what is called a presence, which is centered on a caring acceptance, a nonjudgmental stance, and physical and emotional availability. It is important that he or she give the patient complete autonomy in the relationship. To this end, the spiritual care provider should be capable of respecting divergent points of view.

Assessment is necessary to learn about a patient's beliefs. If the patient is religious, it is helpful to ascertain if the individual believes in God or a higher power and to gain his or her unique perspectives. The patient's perception of his or her disease, suffering, and death can be significantly influenced by their religious beliefs. If the patient is not religious, it is important to find out about other spiritual beliefs and practices. Either way, what may ultimately give a patient a sense of meaning and purpose may be within the context of the particular identified beliefs or outside of that context. Patients may talk of career, relationships, pets, or other aspects of their lives. Connections to a community, religious or otherwise, may be important to patients. The assessment may enable the spiritual care provider to ascertain the parts of the patient's belief system that are supportive, as well as those that may hinder the patient's coping ability.

Spiritual Care Activities

Every faith or cultural tradition is rich with practices and rituals that are of great support to the believer, particularly in moments of crisis. The most common religious ritual is prayer. Many patients have set times in the day when they pray and are helped by having this practice included in their care plans so that the ritual is facilitated. However, prayers need not be formal. They can be a single thought or a wish that the patient and caregiver have been talking about. It may be a simple blessing or simply the silent presence of the spiritual care provider while the patient articulates the prayer. Along with prayer, the reading of texts sacred of the patient's spiritual tradition can be of great support. This too should be included in the care plans so that the patient has time set aside for this reading. When a patient is too infirm to read texts on his or her own, the spiritual care provider can offer to read to the patient from the selected texts (see Appendix I for examples of prayers and texts used in the Israeli spiritual support programs). Both prayer and reading serve as effective methods of relaxation. There are also many other rituals in which patients may find comfort from their own cultures, and some families and patients have rituals they have created themselves. It is important that there be good communication between chaplaincy services and the patient's community in order to help the patient remain connected with his or her community.(Fitchett and Handzo, 1998).

Other rituals can be provided by the spiritual care provider or chaplain. Religious and cultural beliefs may impact practical decisions as well. For example, diet may be an important aspect of a patient's religious observances. Chaplains are good resources to find out information and solve problems.

1.3 The History of Chaplaincy in the United States and Europe

In 1948, the World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The definition includes social and psychological quality of life and is not confined to biological and physiological conditions. This bio-psychosocial model includes the relationship between spirituality and health and encompasses the chaplain's work of providing spiritual sustenance to individuals with physical and mental illnesses.

Chaplaincy was first developed as a profession in the United States in the 1920s by the Reverend Boisen, who believed that ministerial students should study the fundamental struggles of the human soul by observing mentally ill patients (Ford and Tartglia, 2006). Some years later, other chaplaincy training programs began to develop, some of which emphasized probing the depths of spiritual distress. Gradually the concept of clinical pastoral education (CPE) began to acquire momentum and schools started to develop their own training criteria and curricula. Following decades of national meetings and dialogue, the major organizations merged to form the Association for Clinical Pastoral Education (ACPE) in 1967 and established a uniform definition of CPE for the first time (Hall, 1992; Leas and Thomas, 2006).

In 2000, the five largest professional pastoral care organizations drafted a landmark white paper entitled "Professional Chaplaincy: Its Role and Importance in Healthcare" (Association of Professional Chaplains, 2001). The document represented an organized and comprehensive attempt by the profession to create a consensual statement on the meaning of spirituality in healthcare; to explore the vision and values of spiritual care; and to set out the professional obligations and qualifications of professional chaplains. The white paper stabilized and defined the chaplain's role in healthcare institutions (Snorton, 2006).

Chaplaincy has also existed in Europe for many decades (Kofinas, 2006), albeit in a different, less developed form than in the United States. Thousands of chaplains offer spiritual care and guidance to patients and healthcare workers in healthcare settings in countries of the European Union. Chaplaincy in Europe is organized in various ways, often depending on the influence of cultural and religious contexts and social and political factors on the respective healthcare system. In the UK, for example, chaplains play a considerably smaller role than their colleagues in Continental Europe, reflecting cultural and religious differences in Britain. Most European countries have official organizations and associations of chaplains, the majority affiliated with one of the Christian denominations. The major difficulties facing chaplaincies in Europe are the lack of professional status within the healthcare systems and managing to preserve patients' rights to receive spiritual care. The network of healthcare chaplains in Europe invests great efforts in improving cooperation and communication with the medical community (Kofinas, 2006).

1.4 Spiritual Care and the Cultural Context in Israel

Clearly, there is much to be learned from the American and European models of chaplaincy and its relevance to the healthcare and social service systems in Israel. Indeed, spiritual support in Israel is currently in its initial – almost embryonic – stage and many of the challenges facing its implementation are inherent to the essential process of building and developing a new allied medical health profession. However, implementation of spiritual care needs to be culturally sensitive to specific facets of life in Israel – a country that often appears to leap erratically from one dramatic event (e.g., a terrorist attack, war, or unexpected wave of immigration) to the next. It is a place where death and bereavement are everyday occurrences and where pain is frequent and intense. On the other hand, daily life in Israel may lead citizens to search for support, comfort, and meaning, thereby encouraging openness to things that are not immediately visible.

This kind of situation creates a paradoxical situation in which many people search for support and comfort, which encourages openness, while, others close and harden their hearts in their desire to be self-reliant, denying themselves the need for help from others. In recent years, many cultural observers in Israel have noted greater apathy and a sense of helplessness in the population. It is common to hear cynical responses to ideas of spiritual care and attempts to be in touch with our senses, feelings, and the painful realities of everyday life.

Add into this mix the strained relationship between state and religion in Israel and you create another hurdle for the proponents of introducing the ideas of spiritual care into everyday culture. Many program directors interviewed for this report told us that they were perceived by clients

and other professionals as "representatives of the religious establishment," even if they had presented themselves differently and explained their roles. Such perceptions are common among individuals who consider themselves secular and are often suspicious of anything that smacks of organized religion. Conversely, individuals who are observant and consider themselves religious are very suspicious of ideas that appear to come from sources outside of Judaism or from non-Orthodox streams of Judaism. These issues will require further discussion and mutual learning among the organizations, in order to develop approaches and tools to help to address them.

Translating "chaplain" into Hebrew is a case in point. To Israelis, the English word chaplain has the connotation of a non-Jewish priest or minister. The currently acceptable term for chaplain in Israel is *tomech ruchani* – literally, one who provides spiritual support. We have therefore chosen to use the term "spiritual care provider" in this report. Such nuances of language underline the importance for constructing tools in Hebrew that best reflect the ideas of chaplaincy elsewhere in the world, while at the same time developing appropriate terminology for this distinctive profession within Israel. That is to say, a spiritual care provider is not like a rabbi, mental health worker, or any kind of healthcare professional.

1.5 Defining Spiritual Care in Israel

In the United States, many hospitals and hospices employ chaplains to tend to the spiritual needs of patients, families, and staff. While there are clear standards for the training of chaplains, which are published by the Association of Professional Chaplains, defining the work of chaplaincy plainly is a challenging task, partly because it deals with vague and complex notions of the spiritual. However, it is often the nature of the chaplains' work to apply fuzzy boundaries to their work with patients and individuals needing spiritual support. The work of spiritual care crosses many domains, from the medical to the psychological, from advocacy to the emotional, and of course the spiritual.

The situation is similar in Israel. We asked the directors of spiritual care training and service provision programs to describe their understanding of spiritual care in Israel. All of them feel that spiritual care in Israel has strong roots in Judaism and the Jewish perspective of life and spirituality. The other main themes that we were able to extract from their comments included:

- Spiritual care is about allowing individuals to have the space and time to touch the existential and the spiritual in their lives
- It uses each individual's own capacity and strengths for growth and finding purpose and meaning in life
- It creates a space within the maelstrom of illness and pain for introspection and hope
- It draws people out of the narrow confines of their illness, enabling them to realize that they are more than the illness itself – especially in places like hospitals, where above all their illness defines who they are
- It provides comfort, healing and love to individuals who have illnesses or are in distress and to their families. It creates the space for the provider to embrace and hug them physically or emotionally.

2. Study Methods

The information and data were collected from several sources of information, using a variety of study methods. We conducted about 80 interviews of various kinds. These included:

- Face-to-face in-depth interviews with the 22 directors of all of the programs, as well as self-administration questionnaires completed by the same respondents
- Sixteen interviews with key individuals and stakeholders developing spiritual care in Israel
- Three senior directors at government ministries
- Three hospital directors or senior executives
- Three directors of nursing institutions
- Three senior directors of voluntary organizations (e.g., Israel Cancer Association)
- Two senior directors of spiritual/palliative organizations from organizations in the United States and in NAJC. They were interviewed 2-3 times, in different periods of time.
- Two directors of training programs (Interviews devoted entirely to issues concerning the challenges to developing the services)
- Twelve telephone interviews lasting about one hour with students and graduates of the educational programs, using guided questions that had been prepared in advance
- Fourteen face-to-face interviews with patients and family members.

Most of the interviews were conducted by one of the two researchers (NB or SR) and were fully transcribed in real time. We also analyzed the program directors' reports to UJA-Federation of New York. After completing the interviews, we analyzed the material to obtain a comprehensive picture of the current status of spiritual care in Israel. We then returned to some of the respondents for additional information and to verify and deepen our understanding.

Throughout the entire process, we kept an ongoing dialogue with Ms. Elisheva Flamm-Oren, consulted with her and interviewed her with regard to the findings and the insights thereof.

3. Spiritual Care Training Programs in Israel

3.1 Introduction

There are currently nine training programs for professional spiritual care providers in Israel. For the purposes of this evaluation, they have been categorized into three groups according to their target populations and goals:

- Three programs train professionals to become spiritual care providers
- Five programs provide in-service training and education for health and human service professionals seeking to enhance their practice by including spiritual care elements
- One program offers general short, in-service, training to health professionals, as well as conferences, retreats and seminars.

Directors and key personnel in the training programs are well aware of the need to develop the general public's understanding of spiritual care and recognize that many individuals (whether observant or secular) often have initial concerns about these kinds of services. The directors

invest huge efforts and resources in explaining the essence and goals of spiritual care and its potential contribution to physical and mental health. For example, a weekend workshop held by one of the organizations was recently screened on prime time Israeli television and the head of one of the training programs was invited to discuss the programs and the notion of spiritual care. Articles in the media aimed at professionals and the general public serve to increase recognition of spiritual care and provide information about its objectives and contribution.

In the three years since the programs were initiated, they have accomplished the following:

- 60 spiritual care professionals have been trained
- 250 rabbis, community leaders, and educators have received in-service training
- 100 medical or mental-health professionals have participated in in-service training
- 4,000 professionals have been exposed to the field in one way or another through seminars, conferences and workshops

Table 1 shows the nine different training programs in Israel, which are described in further detail below. Interviews with students on the programs are presented in the following section.

Table 1: Spiritual Care Training Programs in Israel (September 2008)

Program	Type	Training Group	Activities	Total number of participants
B'Ruach	**Programs that train spiritual care providers** Tomech Ruchani	All professionals	2 year training programs – 500-800 hours with academic and practical components	60
Mazorim				
Schechter		Rabbinical students	Summer intensive training with academic and practical components	
Avi Hayishuv	In-service training for rabbis	Rabbis and their spouses	Spiritual care units within the general two-year training program	250
B'Yachad		Rabbis and their spouses	7 training sessions, and a Shabbat retreat	
Retorno		Rabbis, community leaders and educators	5 nine-hour training sessions	
Shever V'Tikun (Kolot MSR)	In-service training programs for physical health and mental-health professionals	Senior health professionals	Year-long workshops simulating communication with actors	100
Neve Yerushalayim		Mental-health professionals	Workshops as part of family-therapy training course	
Life's Door (*Tishkofet*)	General training and service provision	Professionals, educators, patients and their families.	Retreats, workshops, conferences	4,000+

3.2 Extent of Program Activities

Programs that Train Spiritual Care Providers

Three programs train individuals to become professional spiritual care providers, in organizational settings that include two rabbinical seminaries and a hospital. They have trained or are currently training 60 people, about half of whom have graduated or are near graduation, while the others are still at various stages of the programs. The programs provide intensive studies and supervised field work focused on spiritual care. Mazorim and B'Ruach are two-year programs, with 500–800 hours in the curriculum. About two-thirds of the time is devoted to content and academic studies in groups or *havrutot* (study pairs) and about one-third to practical experience and personal tuition. The students also participate in simulations with actors, thereby obtaining feedback, at the MSR (Israel Center for Medical Simulation) facility. The third program, at Schechter, consists of intensive summer courses. Until now, there have been two courses equivalent to half of an American unit of Clinical Pastoral Education (CPE) (about 200 hours, including supervised field work) based on the USA model, with a National Association of Jewish Chaplaincy supervisor from NY coming to Israel to train students over the summer, dictating a very small group size (6–8 participants).

In-service Training Programs

The in-service training programs are designed to introduce professionals to the spiritual aspects of issues such as coping with suffering and loss, interpersonal problems, addictions, and others with which the population seeks help. The programs providing this training can be further categorized according to their targeted populations:

Three in-service programs (Avi Hayishuv, B'Yachad, and Retorno) are for ***rabbis, counselors, and non-rabbinical community spiritual leaders***: The target population of the first two programs comprises congregational rabbis and their wives, and the courses are provided externally to students at any rabbinical training course. One of the programs consists of seven training sessions and a Shabbat retreat over a period of three months, while the other program provides spiritual support study units in the framework of a longer course (two years) training congregational rabbis. The lecturers in both programs are specialists in mental health – e.g., psychiatrists, psychologists, social workers, family therapy specialists, and other care professionals. The programs use a variety of techniques such as videotaping and reflection, in order to enhance their use of language and interpersonal communication skills. In addition to rabbis, the target population of the third program (Retorno) includes individuals from educational establishments and community education leaders. This program consists of a five-session intensive course with each session lasting nine hours over a period of a month. In addition to healthcare professionals, some of the lecturers are educators and rabbis.

The purpose of all three of these programs is not to train spiritual care providers *per se*, but rather to provide knowledge, skills and experience to incorporate spiritual care into each individual's own work as a rabbi, teacher, or other community leader. More than 150 people have participated in these three programs.

Two in-service training programs for mental-health and general health professionals, which include mini-courses and staff development training to professionals:

- One program is designated mainly for senior health professionals, such as physicians, nurses, and social workers, with differing religious and secular identities. It is an intensive, yearlong program, implemented jointly by two organizations: Kolot, which is a pluralistic *beit midrash* where secular and religious Israelis come together to study classical Jewish texts and their relevance to life in Israel today, and the Israel Center for Medical Simulation (MSR), a national center for simulation-based medical education. The center strives to change the culture of medicine and improve patient safety and patient-therapist communication skills by developing and incorporating simulation within the field of healthcare education and clinical practice. It uses a wide spectrum of medical simulation technologies including simulated patients, task trainers, virtual reality etc.
- The second program, Neve Yerushalayim, provides education on spiritual care for religious/ultra-Orthodox mental-health professionals, especially psychologists and social workers who are studying for a master's degree in family therapy. It also provides lectures and seminars to healthcare professionals, psychologists and social workers and the community at large.

About 100 professionals have participated in these two programs. In one of them, the professionals meet for a few hours (3–4) every two weeks over a period of nine months, at the end of which there are intensive weekend retreats. In the other program, the spiritual care studies are part of a two-year training course for family therapists. The healthcare professionals trained in these programs are not only able to use the new spiritual care tools in their everyday work, but they are also becoming important ambassadors for the field of spiritual care in Israel.

Life's Door (Tishkofet): General Training and Service Provision

The ninth program, Life's Door, has introduced over 4,000 people to the field of spiritual care through activities ranging from a single lecture, workshop, or seminar lasting a few hours to intensive, two-day conferences, retreats and seminars on the subject. Some participants have attended only one activity; others have participated in several. Among the participants are professionals, public educators, and patients and their families; in several cases more than one target population group is involved in the same activity.

Some of the other organizations also offer lectures to professionals, either regularly (e.g., Neve Yerushaliyim) or when invited to do so by a hospital or other organization (e.g., Mazorim or B'Ruach). Importantly, too, it often happens that more than one organization is involved in organizing a seminar or lecture and sometimes there is international cooperation.

3.3 Program Characteristics

This section describes characteristics of the nine programs, including information about the demographics of the participants as well as the program's advertising and recruitment methods.

Programs that Train Spiritual Care Providers

Demographic and Professional Characteristics

We amalgamated the data from the three training programs to examine the demographics of the students training to become spiritual care providers:

The students represented a wide spectrum of Jewish affiliation: 24% non-observant/secular, 18% Reform, 13% Conservative and 45% Orthodox. Seventy-three percent were female and 27% male. Fifty-nine percent were born in Israel and 41% in North America.

Almost all students in the programs had a professional background (e.g., physician, nurse, social worker, rabbi, or teacher). All of the participants in one of the programs are either rabbis or rabbinical students. In another, about two-thirds are teachers or researchers and the others are health service workers, community workers, and students. In the third program, there is an even wider range of professions: about a third of the participants are rabbis, a third of them are nurses, social workers, and psychologists, and the others are educators or practitioners of alternative therapies.

Marketing/Promoting Training Programs, Admissions Process, and Non-completion of Program

All the programs use many different means to promote their spiritual care training course, including: the Internet, print media, and, of course, word of mouth. All of them have admissions criteria: Candidates must have an academic degree (minimum, a bachelor's degree) and an orientation toward spiritual matters (one of the programs requires an academic background in theology). Candidates are not required to have experience at caring for the ill, but all programs noted that it was important for candidates to have "life experience and show personal maturity."

All the programs have a structured admissions process that requires candidates to submit their resumes and includes a group and/or personal interview. Two of them also ask candidates to write a paper explaining why they want to participate in the course. Directors of all the programs said they had no problem recruiting candidates. The acceptance rate ranges from two-thirds of the candidates for one program to 20% of the candidates for another. Candidates were rejected, typically, if they were unable to commit to the long hours or lacked maturity. None of the program directors think that there is a need to change their current admissions process, but two would like to broaden the range of successful candidates (e.g., immigrants from the former Soviet Union and the Arab population). One of the directors also wanted to offer the training program to master's degree students.

Only one director reported that participants had left before the end of the program and said this was due to a change in the program requirements and to the fact that the course became more intensive, which made it impossible for some of the participants to meet the new obligations. The director emphasized that this is part of the process of developing new programs and adapting them on an ongoing basis.

Job Placement and Support for Graduates

Thirty-five individuals have graduated or are close to graduating from the three training programs. Twelve of them have found paid positions as spiritual care providers in a variety of settings and four more have found similar, unpaid, voluntary positions. The paid positions are funded largely by UJA-Federation of New York through the training organizations, as part of a grassroots movement to encourage the development of spiritual care in Israel. Importantly, funding for a percentage of the paid positions has been secured at three (possibly four) hospitals and in the community. There is a hope that funding from the Federation is helping to encourage other hospitals and community organizations to start taking responsibility for funding spiritual care providers.

The rest of the graduates are using what they learned from the training courses in a variety of professional settings, e.g., as a nurse in hospital or a rabbi in the community. The course directors voiced concern about the challenges facing the training program graduates in finding appropriate salaried work placements. Lack of awareness and understanding about spiritual care makes it a challenge to convince hospitals and community centers to employ spiritual care providers at all, even if they do not have to fund the position.

One program is offering further support to its graduates by providing weekly individual supervision sessions and group supervision once a month. The other two programs intend to implement a similar support program for their graduates.

Evaluation Methods

All the programs conduct ongoing evaluation of the students' activities through *verbatim*, papers written by the students, and feedback on practical experience; two programs also evaluate the students' performance at the Center for Medical Simulation. The directors of all the programs considered that most of their participants had completed the program successfully. The teachers are responsible for tracking the development of the participants' skills and abilities and most feel that they complete the course successfully. However, there are apparently no specific, standard criteria for evaluating the students, nor are there clear/systematic criteria for measuring success. This is an area for further consideration as the field becomes more established and training more standardized.

The programs also receive ongoing feedback from the students, the graduates, and from the field, and constantly incorporate the results into current and subsequent courses.

In-service Training Programs

As noted above, there are two types of in-service training programs – for rabbis and for health professionals – each of which will be described separately, below.

In-service Training Programs for Rabbis

Demographic and Professional Characteristics

All participants in two of the programs are Orthodox. In the third, about half are ultra-Orthodox and the remainder come from Orthodox, Conservative, or Reform backgrounds. In two of the

programs, all of the participants are rabbis or rabbis' wives; in the third program, only 60% of the participants are rabbis, while the rest are counselors or non-rabbinical community spiritual leaders. Most of the participants (70%) are male. Although ages range from 30–60, the average age is only 35. Most of the participants are native Israelis (70%–80%) and two-thirds have an academic education.

Marketing/Promoting the Program, Admissions Process and Non-completion of Program

The programs are advertised in the print media and via outreach, by extending personal invitations to the rabbis or contacting appropriate groups. The prerequisite for admission to both programs is that the candidates be congregational rabbis and that their wives agree to join them and take part in the program. Other admission criteria include: theological training; an academic qualification; and a desire to gain greater understanding of the spiritual needs of their congregants (i.e., a desire to provide pastoral care).

During the selection process, the directors of two of the programs interview the rabbinical candidates and their spouse. The third program has no specific admissions criteria but maintains that it is important that candidates be involved and connected with members of their congregation or have a leadership role in their community. Some applicants are not accepted because they do not have a congregation or an appropriate teaching position. All program directors noted that it is difficult for the rabbis and their wives and for the educators to find the time and make the commitment to the course. Indeed, one of the programs noted that a few rabbis had dropped out because they were unable to meet the time requirements. The program directors do not see a need to change the admissions process, but would like to extend the population of applicants to the entire country, and to include municipal rabbis and students from other rabbinical seminaries.

Evaluation Methods

None of the three programs has a systematic methodology for evaluating the impact of the in-service training course and participants are not required to pass examinations or write papers on spiritual care. However, two programs provide feedback by videotaping the activities. The program directors feel that the most important measure of success is completion of the course. In addition, the course directors hold a final meeting at the end of the course specifically aimed at receiving feedback, which they incorporate in developing the program. In general, the response of participants has been very positive with many course students wanting to initiate spiritual care activities in their communities and expressing interest in continuing with a further course.

In-service Training Programs for Health Professionals

Demographic and Professional Characteristics

In both of these two programs, a third of the participants are Orthodox. In one program the rest of the participants are non-observant, while in the other they are ultra-Orthodox. In one of the programs, women account for about two-thirds of the participants. With regard to country of origin, in one program, 90% of the participants are native Israelis, while in the second, the majority (70%) are from the United States and Canada. Almost all the participants (90%) in both programs have a master's degree. In one program, the participants are health professionals from

various fields (about half are physicians, a third are psychologists and social workers, and the remainder are nurses or paramedical professionals). All participants in the other program are therapists in the field of mental health.

Marketing/Promoting the Program, Admissions Process, and Non-completion

One of the programs promotes courses through print media and by word of mouth, while the other recruits participants more personally through brochures and contacts in professional committees. Both are advertised on the Internet.

Both programs have admissions criteria, which include: being a health professional, having a sufficient degree of self-awareness, and being open-minded to a more holistic approach to healthcare. One of the courses also requires a master's degree in the mental health field. Both programs interview candidates as part of the admission process and the course directors claimed that there had been no problem in recruiting participants to the program, except during the Second Lebanon War, when one of the programs found it hard to recruit male healthcare professionals. The main reason for rejecting candidates is for failing to meet the admissions criteria.

An exceptionally small proportion of participants (2%) have dropped out of the program and this was due to pressures of work or personal circumstances (e.g., giving birth). This may reflect a successful admission process, as well as the high motivation of all participants, since most of them have had to give up or postpone other things in their lives and devote considerable time and energy to the program.

Evaluation Methods

One of the programs uses simulations with actors to find ways of improving the participants' performance. The program director believes that most of the participants completed the program successfully. They obtain feedback, which is used in the further development of the program.

3.4 Conclusion

There are currently nine programs providing spiritual care training. Three offer a variety of ways to become a professional spiritual care provider. Five other program offer in-service training to rabbinical student and rabbis, educators, and a wide array of health professionals. One further program offers a variety of lectures, seminars and conferences to all professionals and the general public. All nine spiritual-care programs have made substantial progress in raising the profile of spiritual care in the Israeli health and social systems. Nevertheless, all those involved in the training programs agree that much more work is needed to show health and social service professionals the potential positive impact of spiritual care. One of the main challenges for these programs is the acute shortage of credentialed spiritual care providers and trainers, which substantially reduces the scope of these programs to offer courses with more accurate focus on the principles of spiritual care. Another challenge is the need to develop uniform standards regarding the curricula and methods by which the programs educate the students, and regarding how they are certified as qualified to provide competent spiritual care.

4. Interviews with Training Program Participants and Graduates

4.1 Introduction

We interviewed 12 students from the three programs providing the intensive training course for individuals wanting to become professional spiritual care providers. At the time, they were nearing the end of their course and four were already working as paid spiritual care providers. Nine of the students were women, three were men. Seven were observant and five were not. The interviews were semi-structured. We present some of the general themes that were shared by most of the individuals who were interviewed. Initially, students were asked about their motivation to study spiritual care and why they chose the profession. Students were also probed for their opinions on the teaching methods and tools used by the programs they attended. In addition, we asked the students to discuss how the program had impacted on them personally and spiritually. We also asked the students to consider their future prospects for working as spiritual care providers in Israel.

4.2 Themes of the Interviews

Reasons for Becoming Spiritual Care Providers

Many of the students reported a natural attraction and prior interest in spiritual matters, end-of-life issues, and death, so the "discovery" that they could study these subjects appealed to them. Students at Schechter also felt that participating in the program gave them an important opportunity, as future rabbis, to broaden their knowledge and develop their ability to cope with difficult existential issues. One student told us that, "As a rabbi, you have to deal with people at difficult times; existential questions come up, questions about life." However, many of them reported that they had often encountered individuals who could not understand why they would be studying such difficult issues, although others had expressed their admiration.

The Training and Learning Process

Most of the students noted in a positive light that their fellow participants had differing background characteristics (age, religiousness, and gender) and professional backgrounds. They said that this facilitated openness and unexpected connections ("One of the lovely things is that you get to the very core … it's not what a student thinks or says, but what goes on beneath the surface."). There were some students who were on a course with a more homogenous student group and they spoke about wanting to see a wider range of individuals. However, two of the respondents suggested that it might be better to separate participants who have a previous background in mental health services, because much of the teaching covered basic therapeutic techniques of which they already have considerable experience.

The curriculum for all three courses has both academic and practical experience components. In this section we report on those that were most important for the students interviewed.

Academic Curriculum: Verbatim

Two of the training programs in Israel utilize the verbatim method, which is a core part of chaplaincy training in the United States. This is the process in which students record an interaction with a patient and then analyze the issues and themes that arise from the conversation. Verbatim analysis is considered to be an important tool, central to the training process, and one which helps trainees develop and grow as spiritual care providers. The students interviewed reported that the most important contribution made by the verbatim is the way in which so many themes, processes, and ideas that go unnoticed during their conversations and caregiving sessions are later brought to light. One student said, for example, that through the verbatim he had learned which component in the discourse "opened up" the patient and led to further conversation. By the same token, verbatim pinpoints problematic areas from which the students can learn and grow. For example, a student said that through her verbatim, she discovered that the patient had tried several times to talk to her about death and she had avoided the discussion.

Academic Curriculum: Group Study and Personal Growth Techniques

Another highly valued pedagogical method is group study. The students said they benefited from this form of peer learning and drew strength and courage from the group. One student said, for example, that initially she had been disinclined to sing aloud with a patient, but having seen another student doing so she changed her mind and started using the tool. Another student described the support he was given by the group to help him cope with the difficulty he experienced over a patient's death: "If you don't bring it up in the group, mull it over, talk about it, you'll break down. You become strengthened. Instead of becoming apathetic, you get stronger."

The courses also use personal-emotional work techniques, such as creating life maps,among students, and introspection of the dynamics among members of the group. Some of the students gave positive reports about this methodology, although some felt that it would have been possible to reduce the "touchy-feely" dimension of the learning process. This issue was mentioned by students at one of the programs in particular, which emphasizes the process of group dynamics and personal change. Some of the students in that program felt that more practical techniques should have been given priority over personal development/group dynamics.

Academic Curriculum: Therapeutic Tools

The students also spoke about other important devices they had learned to use as therapeutic spiritual care tools, such as praying, reading texts, singing aloud, poetry, learning conversational skills and making use of the Israel Center for Medical Simulation. Some of the students said that they would have liked greater and more intensive study of certain tools, e.g., text study, voice work, personal prayer, or to broaden their theoretical knowledge. Another suggestion was that students themselves be given spiritual guidance to enable them to experience the therapeutic process.

Practical Experience

All three programs include practical experience, which the students consider to be essential to their training. However, this is the component that presents the students with the greatest

challenges. Many of them reported an antagonistic reception in hospital wards or other placement environments. In some cases, it is expressed directly, while in others it is veiled and indirect. A few respondents even reported that staff on the ward ignored them completely ("[as if] we were made of thin air") and did not refer patients to them. Some other students reported strained cooperation ("Even if the nurse talks to you, you get the feeling that you're in her way") and a sense of non-acceptance by the staff, manifested, for example, in the fact that they were not invited to eat in the nurses' dining room.

The students offered different explanations for this resistance to their presence on the wards, which included:

- Inadequate preparation of the ward staff about spiritual care. There is certainly less opposition in places where the staff has been given an explanation about spiritual care
- Apprehension among nurses and social workers over the introduction of a new profession in the ward. Specifically, this includes uncertainty about the limits of the new profession and the fear that the newcomers could "poach" some of their duties
- Resentment of many social workers who view provision of spiritual care to be part of their job, but are unable to provide it due to the huge demands of their work and thus feel frustrated to find the task performed by another professional
- Some of the staff members are unwilling to tackle many of the existential issues touched on by spiritual care and see no purpose for its implementation. As one student said, "The doctors and nurses only look at the patient in terms of their disease and what kind of chemotherapy they need. They don't see that there are feelings, there is a family, that there is a soul. They don't do it on purpose – but they block themselves. They don't want to be flooded with these things."

However, not all the students have experienced such antagonism. There was a report of particularly strong opposition to students on one of the programs, while those on another program experienced far more moderate opposition, with almost nothing said explicitly. The experiences of students on the third program varied, depending on where they did their training. They said that when there was a member of staff who understood the contribution of spiritual care and other staffers had been given more detailed and in-depth advance preparation, it was easier for them to get started. We can therefore expect that, as the field is given greater exposure and its contribution becomes more widely recognized, the resistance will be reduced.

Personal Counseling and Facilitation

All the students recognize the huge importance of personal counseling and facilitation and said that it plays several key roles. Firstly, it helps them reflect on their own work, gives another viewpoint on the situation, and provides tools and sets the orientation for their next session. One of them said, for example: "The counseling gives you loads of tools as to the type of questions you can ask to open up the conversation, sensitivity to situations, and ways of coping with difficulties." Secondly, supervision and counseling makes it possible to encourage and reassure the students. One said that, after a meeting with a patient, she felt she had made a mistake that

made her want to quit the program. It was only after speaking to her facilitator on the phone that she calmed down: ("The luxury of being able to speak with the facilitator on the same day and to understand what had happened was worth its weight in gold"). It is, however, important to note that two students said that the facilitator should be a spiritual care provider himself, because psychologists cannot always come up with appropriate comments for spiritual care.

Quality of Teaching on the Training Course

With regard to the teaching staff, all the students rated the three program leaders/trainers extremely highly. When asked, "What element of the program would you like to retain?" many answered "the trainer." They students see the trainers as role models and sources of inspiration. One student told us that the charisma and character of the trainer was "…infectious… inspiring. It has the effect of being with great people." Furthermore, the students in a program with a facilitator from the United States were not bothered by the fact that she was not Israeli. However, not all the regular teachers in the programs enjoyed such a high evaluation. One of the most salient weaknesses noted when students were asked about the less-appreciated teachers, was that they lacked the ability to impart knowledge and tools with practical applications.

With regard to what they felt was missing, some of the students said that they would like more lectures by guest speakers rather than the permanent staff, while others noted they would like to learn by observing teachers whom they respected, particularly the course trainer. They proposed increasing the opportunities for observing their facilitators at work, for example, by using a one-way mirror – a tool not used at present.

4.3 Students' Perspective as to Whether the Training Programs are Creating Spiritual Care Providers

The students feel that the program is achieving its goal – to train spiritual care providers. They reported that they had professionalized, acquired tools, assimilated content, and developed an understanding of their position vis-à-vis the patient. For example, one student said: "I am becoming more specialized in recognizing tools I can use (such us texts) and in my ability to understand the patient, to see where I can help him." The students interviewed also described how their participation in the program had helped them to develop and grow as human beings and allowed them to express their spiritual inclinations. They also reported that the program helped them to grow as people, with the ability to cope with patients and difficult issues, and they stressed the connection between personal and spiritual development and their work as spiritual care providers. One of the students said, "I felt what it was doing for me and I could take the 'spirituality' gained from the program and transfer it to the patients in other ways."

4.4 Finding Positions as Spiritual Care Providers

Job placement is paramount. As discussed in earlier sections, the profession is not well known and there are only few paid positions for spiritual care providers in Israel. Consequently, the process of finding a place of work for students (even unpaid or funded through donations) is complex and challenging. It requires a tremendous amount of time, energy, and commitment

from both students and program coordinators responsible for placements. Four of the respondents are currently working as paid spiritual care providers and a further six are seeking work either as part- or full-time spiritual care providers. Two of the respondents told us that they did not intend to become spiritual care providers and were doing the training so they would be able to incorporate the knowledge and experience into their work.

The respondents who are already working as spiritual care providers reported a sense of security at their places of work and said they enjoy full cooperation from other members of staff. Graduates who are not currently working in the field naturally expressed less certainty. They have confidence in their ability to provide care to patients, but are worried that they will not find work or may have to cope with the sense of rejection by other members of staff. They also expressed concern about having to negotiate with potential employers, particularly if they wish to be on the payroll rather than to work as volunteers.

The program graduates attach great importance to the support and guidance they receive in their work, which includes professional counseling from a spiritual care provider, even after the conclusion of the program. The counseling also enables them to talk over their dilemmas, discuss issues that arise during their work but were not taught in the program, and to cope with other staff members. Students without support said that they felt the need for it. Significantly, the students said it was very important that the person providing support at their place of work during and after their practical training should be a spiritual care provider and not a professional from another area such as a psychologist or social worker.

4.5 Conclusion

The three programs appear to be successfully training spiritual care providers and providing their students with a comprehensive range of tools to help them work in that capacity. The most important tools appear to be: practical training alongside their studies, verbatim writing, and personal counseling. The students expressed great appreciation of their facilitators as teachers and as human beings and considered them to be important role models. Enormous resources are currently invested in placement of the students and in supporting graduates. These – evidently essential – efforts are demanding, but ultimately they contribute significantly to successful placement opportunities.

The issues expressed by the students reflect a general challenge of incorporating spiritual care into the hospital and social service systems in Israel. One way the programs have attempted to overcome any concerns of antagonism toward spiritual care has been to prepare staff for the practical training stage (particularly in the case of one of the programs) and provide the students with better skills to deal with this sensitive situation.

5. Interviews with Directors of Spiritual Care Programs

5.1 Introduction

UJA-Federation of New York is funding spiritual care programs in eight organizations. At least 7,000 individuals have participated or received services at least one time from these spiritual care programs in the last three years. This represents an auspicious start to the development of such programs in Israel.

Five of the organizations have introduced tailor-made spiritual care programs into their existing frameworks and worked with 2000 individuals over three years. The other three organizations have opted to not create specific programs, but rather to incorporate the principles of spiritual care into their general programs. These programs worked with approximately 5000 individuals over three years.

Six programs operate in the community as self-help support services while the other three operate in a more institutional settings (a general hospital, geriatric hospital and an old age home).

All the spiritual care programs were developed and established by organizations based in Jerusalem and most of their services are provided in this region of Israel. Three of the programs have extended their activities to other parts of the country, mainly in the north (Zichron Yaacov, Afula, and Haifa), and one of them also started its activities in the south. With regard to the geographical distribution of the graduates, those who are working are doing so throughout the country.

Table 2: The Eight Organizations Implementing Spiritual Care Programs

Organizations Offering Tailor-made Spiritual Care Programs				
Organization	**Type**	**Population served**	**Region served**	**Summary of activities**
ICCY	Community Center	Elderly	Jerusalem	Group support
Herzog	Hospital	Elderly	Jerusalem	Individual support
Ma'agan	Community-based	Cancer patients and families	Jerusalem	Group support
Koby Mandell	Community-based	Victims of terror attacks	Jerusalem and northern Israel	Group support
B'Ruach	Hospital	Cancer patients and families	Jerusalem	Individual support

Organizations that Have Integrated Spiritual Care into Existing Programs				
Organization	**Type**	**Population served**	**Region served**	**Summary of activities**
Life's Door (Tishkofet)	Community-based	Patients and families facing loss, suffering, and illness	Jerusalem and northern Israel	Individual and group support
Hatomechet	Community-based	Cancer patients and families	Jerusalem , northern and southern Israel	Individual support
Neve Yerushalayim	Community-based	Individuals and families	Jerusalem	Individual and group support

5.2 Who Benefits from the New Services?

These eight organizations work with a wide variety of individuals with different needs. Three programs work with cancer patients and their families, although generally not with terminally ill patients. Two of the programs for cancer patients operate in the community and the third is at the oncology department of a general hospital.

Two programs have tailor-made spiritual care programs that work with an elderly population. A further two programs focus on issues to do with loss, suffering, and illness, as well as providing support and guidance to family members and formal caregivers. One program works with individuals who have lost a family member in terrorist attacks and need support in coping with their bereavement. In addition to operating a spiritual care program, one of the organizations also has taken on the responsibility of raising awareness in Israeli society about the value and importance of spiritual care in health and social service settings.

Most of the individuals taking part in the spiritual care programs offered by the eight different organizations are women. The program directors are hoping to increase the number of men taking part and are developing different methods to achieve this aim. The age-range of the participants is very broad, with adolescents in programs for cancer patients, family members of terrorist victims of all ages, and elderly people in the geriatric services. The average age of participants across these programs is 50. Most of the participants are native Israelis and virtually all are Jewish. There is, however, diversity in the level of religious observance or non-observance among the participants.

5.3 What the Programs Do

The programs differ in whether they offer individual or group support. This depends on the framework in which the organizations provide services and on financial considerations. Two programs provide both individual and group care as part of their spiritual care service. Three of the other six offer group support only; the other three provide individual support. Overall, the program activities last from a few months to more than a year.

The framework of activities varies from weekly meetings with the spiritual care provider to an evening of community workshops (about loss, for example) or a weekend retreat. Within these settings, many different modalities of care have been incorporated into the spiritual care services provided: Reading and studying Jewish and other texts, group prayer, composing personal prayers, personal writing, relaxation, meditation, guided imagery, yoga, movement therapy, dance, poetry, art therapy, family therapy, psychodrama, focus on the relationship between mind and body, and gardening.

5.4 Professionals Involved in the Programs

The directors make great efforts to recruit professional staff of the highest caliber, such as bereavement specialists, therapists (bibliotherapists, art therapists, etc.), psychologists and psychiatrists, social workers, organizational consultants, supervisors, and volunteers. However, there are very few trained and formally accredited spiritual care providers in Israel. Moreover, the few who have already accumulated experience and professional knowledge are in great demand and frequently work in several programs at the same time. This means that the spiritual care programs are often implemented by therapists and health professionals who have a great deal of knowledge and experience of their own profession, and awareness and connection to spirituality, but have little formal knowledge and experience of the principles of spiritual care.

The vast majority of professionals working in the programs are paid. One of the programs works mainly with volunteers who are supervised and coordinated by paid professionals.

5.5 Participation Fees

There is no charge for individuals receiving spiritual care in six of the programs. The directors of the programs are convinced of the importance of reducing participants' initial resistance to such services, although they expressed concern about the long-term funding implications.

Two programs do charge for their services. These organizations do not have tailor-made spiritual care services, but have incorporated the principles into other programs. As these organizations charge participants for most of their services, it seems entirely appropriate to charge for the programs with components of spiritual care. However, in most cases, the payment is reduced and is lower than that charged for other services.

5.6 Challenges Faced by the Organizations Implementing Spiritual Care Programs

Many of the directors expressed similar concerns about the challenges of implementing innovative programs, such as those incorporating spiritual care.

Ensuring Sustainability through Publicity and Fundraising

Some of the directors reported that they are constantly concerned about sustainability of the program and that much of their time is spent endeavoring to raise sufficient funds to continue providing their services. At the same time, there is often a strong desire to improve and expand program activities. One director reported, for example, that she would like to extend activities to

the ultra-Orthodox community and to the Arab population, who seldom contact her organization. Many of the directors also want to broaden their volunteer base and most of the directors want to extend their organization's activities and programs to other parts of the country, but are constrained by budgetary limitations.

Limited budgets notwithstanding, all eight organizations work extremely hard to reach the broadest possible population and to increase participation in their programs. They use a range of tools to disseminate and advertise their activities including spiritual care. Some have websites or present themselves through the media, mainly through newspaper but radio and television as well. All produce brochures about their target populations and activities. Many of the organizations use academic and professional conferences to publicize their activities to other professionals. Some of the programs approach potential participants directly. The directors of these organizations also recognize the value of word-of-mouth recommendations to potential beneficiaries of their programs from participants and the professional community.

All the organizations attach great importance to consolidating and expanding their activities to ensure sustainability. Many of them fundraise abroad. Four of them have active boards in the United States as well as in Israel in order to promote fundraising. Some produce fundraising events in Israel and try to recruit well-known or wealthy individuals as donors or social leaders.

Professionalizing Spiritual Care

As noted, there is currently an insufficient number of spiritual care professionals to meet the demand and we envisage that as the profession develops and is better understood in Israel, there will be even greater demand for qualified providers.

Time Limitations

Many of the directors of the spiritual care program find it a challenge to implement time-limited programs – many participants want more than has been planned. This constitutes a dilemma for the directors. They want to augment their services to their clients, but are constrained by budgets.

5.7 Conclusion

In a very short time, nearly 7,000 individuals have been directly and indirectly helped through spiritual care services in Israel. The eight organizations described in this chapter have contributed hugely to raising public awareness of the value and use of spiritual care. Among the beneficiaries are: cancer patients, diabetics, people with terminal and/or chronic illnesses and their families, the elderly, victims of terrorist attacks, and individuals facing acute existential problems such as transition issues, bereavement, and death.

The programs differ greatly in substance and in their definitions of spiritual care. This creates a challenge for the proponents of spiritual care and they will need to develop a standardized definition of spiritual care, if it is to be accepted within the Israel health and social system. There is an acute shortage of spiritual care practitioners in Israel, which limits its potential development. The program directors interviewed also identified groups of individuals to whom greater outreach is needed. These include: men, the Orthodox and immigrants from the former Soviet Union.

6. Spiritual Care as Experienced by Patients and Their Families

6.1 Introduction

We interviewed a sample of 14 patients and/or their families to evaluate the impact of spiritual care on their lives. The respondents were recruited by their spiritual care providers and interviewed by Myers-JDC-Brookdale researchers. All the respondents had received spiritual care services from B'Ruach at Shaare Zedek hospital. They represented a broad cross-section of Israeli society and comprised men and women, Jews and Arabs, people of all ages between 26 and 86, holding different religious outlooks. The interviews were conducted in the patients' homes using a non-structured interview technique to facilitate an open discussion about the value of spiritual care.

In this section, we describe the narrative context for two of the respondents, which will provide a deeper understanding of the value of spiritual care. We also give a general description of the many different opinions expressed by the other respondents. The names and identifying information have been changed to preserve the anonymity of the individuals who took part in the evaluation.

6.2 Ruth (age 85)

Ruth is an Orthodox Jewish widow, who immigrated from Western Europe and has lived in Israel for more than half her life. Her father, husband, and sister all died from cancer. She has been diagnosed with lymphoma and carcinoma and has undergone many operations. She currently lives in an assisted living scheme in her own apartment and is largely independent. She has a close relationship with all her children and many of her grandchildren and great-grandchildren. She has a great exuberance for life, and told us "I am almost 86 years old, and I hope to be around for a long time to be with my grandchildren and great-grandchild."

She sees herself as a spiritual person with faith in God and believes in being observant especially of Shabbat. She feels it important to be aware of nature and appreciate its beauty. In the interview, she compared the renewal of life in trees in springtime with the renewal of her own life after each stage of treatment. She sees herself as a fighter, unwilling to give up the struggle for life.

Ruth had received spiritual care services both individually and as part of group in a community setting at Ma'agan. She had participated in music therapy and thought she would try out the new spiritual care group that was being offered. While attending this group, she was hospitalized several times. Having already met the spiritual care provider and experienced first-hand what she could give her, she was pleased to have the opportunity for individual counseling. The relationship has been maintained for several years.

Ruth talked about the spiritual care group she attended. At the most practical level, she recognized that it was an opportunity to get out of the house and meet other people. Another advantage of the group is that it makes her fell less alone, because she can talk and share experiences with other people who have experienced illness. She does not feel the need to explain or even to maintain the effort to protect other people (especially her family) from knowing about her experience of illness. She loves learning, reading, and analyzing the texts brought to the spiritual care groups. Ruth mentioned a song that they had learned, about a ship's captain who did not know their destination. She said, "We are also sailing, and nobody is telling us where we are sailing to and how it will end."

Of her experience in hospital, she talked about the spiritual care provider's ability to take her thoughts to another place, far from the clinical wards where she stayed during her treatments. It also took her away from frightening thoughts that were present in the hospital – thoughts like "Am I going to end up like those people – alone, with no vitality and strength?" Ruth's spiritual care provider was able to give her the energy and vigor to look at her life more optimistically.

Ruth explained that there were many ways in which the spiritual care provider is able to do this. "She is able to dissipate my fears – she is always in a good mood, laughing and smiling… It's pleasant to be with her… it makes you less miserable." Ruth also talked about the importance of her spiritual care provider's physical touch – the holding of hands – and how soothing it is. Ruth sees the spiritual care provider as someone who can provide her with a space solely for her needs, in a way that could never be given by the other hospital staff. "The nurses are always busy and don't have a personal connection with me. They ask about pain only because they need to record it in the medical notes."

It is also important to Ruth that this personal connection feels authentic and real. She spoke of her delight in meeting the husband of the spiritual care provider and there was a sense she was not just another hospital person but a real friend, someone who was able to "hold all my worries" – a container of Ruth's fears and hopes, which then allowed her not to burden her family.

6.3 Sara (age 45)

Israeli-born Sara lives in Jerusalem with her husband and a large number of children. She is an ultra-Orthodox teacher at a local religious elementary school. When she met her spiritual care provider, Lilach, it was during her second incidence of breast cancer, four years after the first. Her sister had died from breast cancer. She describes herself as a strong person, with an unshakeable faith and optimism about the future. Sara's response to her first illness had been to become a volunteer herself for other women in the community who had breast cancer and were from a similar background.

She said about herself, "I am the kind of person who sees the world in warm colors," although she had learned from Lilach how to assimilate the darker sides of life and saw this as important to her personal development and growth.

Sara recalled the happy circumstances of her first meeting with the spiritual care provider. She had thought Lilach was offering massages to patients in the hospital ward, and was surprised to hear that she was providing spiritual care. Had she known, she did not think that she would have sought help or support from Lilach because of her non-religious appearance and her interest in Eastern traditions. However, she is certainly happy that these initial impressions did not dissuade her from entering what she now considers to be a very meaningful relationship.

We asked Sara about the spiritual dimension of Lilach's support and how it fitted in with her own religiosity. She told us that "I still have my rabbi, whom I turn to for questions of faith," but said that Lilach offers her many other things, such as the opportunity for each of them to learn from the other about Judaism and spirituality. She also feels that with Lilach she is "able to let go" – there is no need to put on an act or be strong, or to put on a face for family and friends. That it is "OK not to be OK in life all the time."

Sara also talked about how her feelings were contained by Lilach. She described Lilach as being able to "negate her own feelings" in order to make room for the painful ones, which Sara expressed as "[she] puts her own feelings on one side to make space for the pain I express." At the same time, Lilach is not afraid to confront difficulties and discuss them with Sara. For example, when it was Sara's birthday, she was disappointed that neither her husband nor children were going to celebrate it. She was not able to express her yearning for more of a celebration, but Lilach gently enabled her to self-advocate so that she was able to request a party from her family.

She explained how Lilach differs from other healthcare professionals: "All the other professionals are busy. They are [busy] for me, but also for everybody else… There is something inviting about Lilach … she initiates the contact… she makes you feel that she is there for you and you alone." Sara also talked about the importance of both sides of her healing – the medical and the spiritual – and said it made her appreciate the value of spiritual care provision in the hospital.

In the end, one of the most important insights that Sara has gained from her encounter with spiritual care is the realization that "inside we are all the same… we are dealing with the same problems and issues… and even though we are externally different, we all have the same core… I learned to respect something different."

6.4 Themes from the Narratives

These two narratives have many similar themes in common and they recurred, with variations, in all the interviews we conducted. Among them:

- The intimacy between recipients and providers of spiritual care
- The use of spiritual care tools such as texts, prayers, and songs
- The ability to talk about difficult subjects
- Spiritual care providers capacity to focus on each person individually
- Empowerment and advocacy
- Spiritual care providers knowing how to say the right thing

Intimacy

Perhaps one of the most powerful themes is the expression of an unthreatening intimacy and trust between respondents and the spiritual care provider. The respondents noted that spiritual care providers feel like friends who are willing to share their own fears and hopes. They also reported physical contact – "We hold hands, she sits close to my bed" – which is an important part of the experience of spiritual care for many of the individuals we interviewed.

The respondents used adjectives such as pleasant, intelligent, affable, wonderful, good-humored, jovial, gentle, relaxed, and peaceful to describe the care provider. One of them described her spiritual care provider as "gentle, loving person, with depth of personality and knowledge, a desire to help, and an ability to recognize what to say or do."

One of the respondents had been a caregiver for his wife, who had died of cancer. Both of them received support from the spiritual care provider. "In the last of hour of her life, she [the spiritual care provider] gave me hand cream to put on my wife hands, so that she would feel the touch [the connection] between us – [and know] that we were with her until the end." It is in these moments of intimacy that the spiritual care provider can have a uniquely powerful and healing role. In this particular story, the benefit to the respondent was that process of saying goodbye was structured by the spiritual care provider and was an important part of his grieving process.

Use of Care Tools

Many of the individuals we interviewed talked about the importance of the tools used by the spiritual care providers. For example, some make use of breathing and relaxation exercises and emphasize the importance of experiencing nature by taking walks in parks. As one of the respondents said, "She told me to walk, to see the flowers, the trees, and the birds. She persuaded me to come back to life and to do things that are not connected to being ill."

There is also great use of texts, such as the weekly Torah portion, Jewish or Rabbinic stories, and poetry. The readings provide ideas for coping with illness and the challenging existential realities in life. One respondent told us that "the texts bring up questions about when to seek help, and from whom, and whether the help will be sustaining or draining. The studying releases things hidden deeply in your soul and allows them to flow." Studying the texts can provide insights that free the individuals from the mélange of feelings and thoughts that have held them back from requesting support.

Another advantage of the texts is that they stimulate curiosity about things that are not usually discussed, which are then taken home after the session or group. One person we interviewed told us that "in the evening, instead of wallowing in self-pity, I read the texts." Many of respondents find the texts to be very comforting and said that there were many sources of insight and support to be found in the Jewish tradition. One person told us that "the texts help raise me to new levels of awareness and connect me to larger and greater ideas and themes in life; more than just what is happening to me."

In addition to talking and reading, the spiritual care providers make use of tools such as poetry, prayer, and sitting together in silence. One of the respondents told us about the time when her husband was undergoing a bone marrow transplant and he was extremely tense and nervous. "There was a guy who sang and played guitar… and he came to my husband and sang some songs to him. After this, I could see how my husband was able to release the tension…. Once he was asleep, the spiritual care provider then offered me a song for myself."

Talking about Difficult Subjects

Issues that have to do with the illness, the fears, and the coping – things that the patients do not want to talk about with their families so as to not worry them – are also brought up in conversations with the spiritual care provider: "I could share my innermost, great anguish. Noa [the care provider] isn't alarmed. I can't speak with my loved ones – the family and children – about a hospice. Noa doesn't collapse or fall apart. She says she'll be with me. It's incredibly liberating. She's here for me in my darkest and most frightening moments. She gives me her blessing for my 'journey' by showing me the way to go."

Having Time to Focus on Every Person

"Being, not doing" is a basic tenet of spiritual care, and this is reflected in the individual focus that spiritual care providers are able to give patients. One of the individuals interviewed said that a good spiritual care provider is a person who connects with every patient in the most suitable manner: "The spiritual care [provider] is ready to connect with each person and his sufferings, without standing on ceremony. They connect directly with the problem." This reflects an important theme – that of the spiritual care provider's ability to find ways to be compatible with individuals from a variety of cultural backgrounds and with very different needs.

This is something that most healthcare professionals are not able to provide or be sensitive to. In addition, the ability to focus on an individual's experience of life-threatening illnesses allows for the opportunity to explore important personal issues and themes that have significant on life beyond that of the illness. As one of the respondents told us, "When she sat with me, she gave me the feeling that I was the only person in the world… she's not here to fill in the boxes on my hospital chart."

Empowerment and Advocacy

For many ill people, treatment is often a disempowering experience. The respondents were struck by the sense of empowerment they gained from their spiritual care provider. Rather than focusing on the struggles, pain, and losses, the spiritual care provider helped many of the respondents to recognize their strengths and hopes. One person told us, "He said that it showed that I was person blessed with riches… he liked how I was a parent and grandparent." This is process of making the individual feel validated.

The spiritual care providers' intimate familiarity with the patient enables them to mediate between the patient and other staff members. Several of the respondents were appreciative of this advocacy role; "It's a luxury to have her [the spiritual care provider] on the staff helping patients

with being an advocate. If I had a wish or worry, I shared it with her and with sensitivity she helped the staff understand, without confrontation."

Sometimes, the spiritual care provider had an advocacy role between family members. One of the respondents told us, "I wouldn't go to the nurse to ask for her help in asking my son to come with me to radiotherapy. With Noa [the spiritual care provider], everything – distress, wishes, needs – comes up."

Saying the Right Thing

Many of the respondents were impressed by their spiritual care providers' ability to be flexible in what they said and did. They noted that the providers were often able to adapt to different people's needs. For example, one person told us, "She [the spiritual care provider] was perceptive about the people she was dealing with. She knew how to speak with my husband who was ill [who had very different needs] and that she needed to speak to me differently…. With my husband she spoke about his academic work, and with me about the books I had been reading."

6.5 Fears about Spiritual Care

Although we received very positive feedback from everyone we interviewed, there were some caveats about spiritual care and some hopes about how it might be further developed in Israel.

Religion and Spirituality

Some of the respondents reported that when the spiritual care provider first contacted them, they felt apprehensive about something that appeared to be religious or New Age. In particular, there was some concern about the Hebrew word for "spiritual," which has many connotations. For example, one man said, "The word 'spiritual' winds me up … it sounds like some crazy Eastern sect doing weird things like idol worship."

Spiritual care is something that can be hard to categorize, especially for the ultra-Orthodox, who may be concerned that it could be outside of the boundaries of Jewish law and community acceptance.

Ambiguous Boundaries

Some respondents wondered about the need to define the relationship with the spiritual care provider more clearly and make the patient's wishes and the spiritual care provided more compatible. The frequency of visits from the spiritual care provider was also mentioned. Another patient said that she did not always know when she could (or should) call the spiritual care provider and when she should not, and another said that "In certain situations, I'd prefer her not to interfere."

Similarly, there was discussion about the location where the care should be given, particularly after a patient has left the hospital. Some said that the provision of spiritual care only suited them on the hospital premises: "I'm really not up to having him come to see me at home. I let him come once, because I didn't like [not to] … While I was having treatment at the hospital, it

helped." It may be that patients felt this was a new profession at the hospitals, one in the process of development, and that its limitations had yet to be clarified and elaborated.

Prioritizing Needs

The respondents were asked to consider who would benefit most from spiritual care services. Some suggested that priority should be given to people who are on their own or to those suffering from depression, or parents of small children. Some of the respondents were caregivers who had themselves received spiritual care. One person told us that her mother was dying of cancer in the hospital; the only person within the health and social service system who provided comfort to her as caregiver was the spiritual care provider. She told us, "When you are with someone as they are dying, there is the feeling of being in vacuum… you feel alone… you are the only one feeling this way… but it us the spiritual care provider that can pull you out [of this lonely place]… the only light in dark times."

6.6 Conclusion

The respondents interviewed for this section represented a wide cross-section of Israeli society and all of them were able to express the uniqueness and importance of spiritual care clearly, especially in the context of health environment, which is often perceived as sterile and cold. In particular, for most of the respondents, this meant that the spiritual care provider was able to be a warm, individualized, and connected presence in their lives. In the context of illness, death and loss, the spiritual care provider was recognized as a provider of light.

7. Attitudes of Stakeholders and Policymakers towards Spiritual Care

7.1 Introduction

To better understand the challenges facing the development of spiritual care in Israel, we conducted 15 interviews with a broad range of stakeholders. All of them responded positively to our request to take part in an interview about spiritual care, even though most had very limited knowledge of the subject. Their keenness to participate was partly out of curiosity, but was mostly because they were interested in finding out about new ways to enhance the quality of the lives of patients and other people in distress.

All the interviews were personal meetings that lasted about an hour and they were conducted at the respondents' offices. They took the form of a free and open discussion facilitated by a guiding questionnaire that had been drawn up in advance. All the interviews were transcribed in full and analyzed using qualitative study methods.

7.2 Findings

Achievements

The directors of two hospitals said they were familiar with spiritual care. In one hospital, the spiritual care services are implemented in the oncology department and in the other, which is a

geriatric hospital, the services are supplied to several geriatric departments. Both directors had gained experience and knowledge of spiritual care during their own medical training in the US and were both happy to receive funding to develop their own programs in their hospitals. According to these two directors, the implementation of spiritual care has had an enormously positive and meaningful impact. They described how their appreciation and recognition of spiritual care's unique role and importance had grown stronger over the three years since its introduction to the hospital.

They also feel that the reports from the patients, their families, and staff members have given them an idea of what spiritual care contributes, of the seriousness and professionalism of the care providers, and of spiritual care being "something special." The director of the hospital in which the services are currently implemented in the oncology department only said that heads of other departments had recently expressed interest in the service and asked for the spiritual care provider to visit their departments too. To quote one of the directors: "After I received feedback from patients, staff, and others, I attributed greater importance to the subject and raised it to a considerably more prominent position in the rankings of unconventional treatments in the hospital."

Both directors felt that these radical changes could not have happened without the funding from UJA-Federation of New York, which had made it possible to introduce spiritual care services into the hospital system as a pilot. It has become clear that there was a need and demand for such services. They said that it would be difficult for them to employ spiritual care providers through the hospital's regular budget. However, they added that, given their very positive experience of spiritual care, if the current funding were to be discontinued, they would make strenuous efforts to raise alternative funds to ensure that the activities continued.

One of the hospital directors said: "Were it not for the donation, [spiritual care] wouldn't have had a chance. Even though it was a matter of principle for us, we needed not only the donation to get started, but also long-term financial support. It's only now, when it comes from the field, that we have the power to go to the donors and say that it is making a contribution, that there are reports from the staff, family, and patients that our care is contributing to them. And now, other wards are asking for the spiritual care provider to go to them."

7.3 Challenges

As noted, at the start of their interviews, most of the stakeholders said that they had little knowledge about spiritual care, and virtually no direct experience of it. Many common themes and concerns emerged from their interviews, including:

- Lack of knowledge and understanding about spiritual care
- Confusion as to the difference between spiritual and religious
- Concern about how healthcare and social service professionals would relate to spiritual care providers
- The challenge of introducing new ideas and programs in Israel

- Funding
- Finding a way to develop spiritual care and successfully integrate it into the general health and social services systems

These are explored and analyzed below.

Lack of Knowledge and Understanding

The first concern is the lack of even the most basic knowledge about spiritual care, which makes it difficult for the respondents to evaluate the suitability of spiritual care for their organization and determine whether patients or consumers would want it or be prepared for its introduction. Even after they had been given a short explanation about spiritual care, they repeated emphatically that they would need far more detailed information and raised many elementary questions such as: What is the profession? What do the spiritual care providers do? What makes it special? Who is involved? Who are the care providers? What is their training? What tools do they use? What is the target population? What contribution does it make?

Two directors of long-term care institutions said that they had been offered a volunteer professional or trainee spiritual care provider, but had turned the offer down because they had not been given satisfactory explanations about what the work would entail. Other respondents expressed concern about allowing volunteer "therapists" onto their premises without a complete understanding of how they would work with the patients. There was general concern about whether there was any danger from spiritual care and its impact on mental health and wellbeing.

Two heads of ministerial departments said that they had encountered spiritual care providers (chaplains) on a study tour of hospitals and other institutions in the United States. Other respondents were aware that spiritual care was a way to empower patients to use their own inner resources for healing. Some of the respondents believe that this form of care has religious aspects; others said that it was their understanding that support did not come from religious sources.

Confusion between Spiritual and Religious

Many respondents are confused about the relationship between spiritual care and religion. This is particularly relevant in Israel, where there is often great tension between non-observant and religious individuals. Unlike the United States, where the involvement of a member of the clergy is often a positive and important part of the care for terminally ill patients and their families, in Israel such involvement may be more controversial and considered more negatively. Some Israelis have antireligious attitudes stemming from the non-separation of religion and state and therefore do not want to have a religious person present or involved during their difficult moments.

In this context, some directors of institutions expressed apprehension about the possible link between spiritual support and religious activity and the involvement of religious institutions. They feel strongly that their institutions are not places for religious activity. Some skepticism was

also expressed about the involvement of Reform Judaism in the development of spiritual care. Other respondents also have concerns that the spiritual care movement evolved from a Christian paradigm of pastoral care. For example, the director of a large old age home in Jerusalem, in which most of the residents are Orthodox Jews, recalled that a visit from a female spiritual care provider wearing a skullcap had upset many of the residents. He told us "Spiritual care has links to Christianity. It's not a Jewish concept. It has Christian connotations and it could disturb the staff and the elders… If we joined the program, we'd have to change the name, because that name is unacceptable to us."

The challenge here for both implementers and providers of spiritual care is to emphasize the difference between spiritual care and religious observance; at the same time it is important to be sensitive to the feelings of religious Jewish individuals who often consider them to be the same thing.

The Relationship between Healthcare and Social Service Professionals and Spiritual Care Providers

Many of the respondents are concerned about any potential conflict between spiritual care providers and other healthcare and social service professionals. In particular, concerns were expressed about the potential negative response of social workers, who consider emotional support to be an integral part of their own work. However, social workers are often tied up with administrative aspects of their job and it is hard for them to find the time to talk with their patients. This is something that they themselves complain about, but nonetheless it could cause – and in some cases already has caused – opposition to having a professional from another field perform the task. There were also reports that nurses too consider themselves providers of emotional support; consequently, they see no need for spiritual care providers and may actually object to their introduction.

One method that some of the directors responsible for implementing spiritual care in their organizations use to address the issue is to involve other professionals in the development of these programs and the recruitment of spiritual care providers. These directors also emphasized the importance of ensuring that spiritual care providers be an integral part of any team providing care to patients.

Introducing New Ideas and Programs in Israel

The policymakers at government ministries talked about the challenge of working with Israeli and non-Israeli philanthropic organizations in developing innovative programs. One of the main issues is working with organizations and individuals who may not have a complete understanding or first-hand experience of the complexities of Israeli culture, society, and organizational culture, which might impact on the development of innovative programs. The policymakers claim that although external philanthropic organizations understand the necessity of working in partnership with government, municipal, or public agencies to ensure continuation and sustainability of new programs, they do not always do so. They emphasized that this is not just about long-term funding issues, in which the seed money for new initiatives is reduced over three to five years and

is eventually discontinued. They are also concerned that there should be more consistent cooperation and improved dialogue between Israeli authorities and service providers and overseas funders.

This issue is particularly complex when it comes to spiritual care and the like, since policymakers and directors of government ministries do not deny that it is almost impossible to develop new services with their own resources. They therefore have an interest in adopting services and projects that have been already found to be effective and efficient before they invest in them. In other words, they recognize the importance of developing services from the bottom up, and some even admit that this is the only way to develop new services. Furthermore, some said that they had been invited to conferences and seminars at which the issue was discussed and a few had even participated in one or two meetings. However, despite this, they did not feel that they had been sufficiently involved in the development processes.

In this context, note that work from the earliest stages of developing this field in Israel was conducted in partnership with JDC-ESHEL (the Association for the Planning and Development of Services for the Aged in Israel) and JDC-Israel, which brought representatives of government ministries and the Federation together round the discussion table. Since JDC-Israel is highly skilled in this role, which is one that it performs regularly, the representatives of UJA-Federation of New York invested resources, thought, and efforts in order to involve JDC-Israel from the start, believing that a subject such as spiritual care could not be addressed using the "cut and paste" method to transpose it from American culture into the culture, language, experience, and organizational behavior of Israel. Furthermore, resources and efforts were invested in sending representatives of JDC-Israel to meetings and conferences of the National Association of Jewish Chaplains (NAJC) out of appreciation of the importance of assimilating spiritual care in Israel. However, in this context, it should be noted that in Israel (and perhaps elsewhere) health and social policymakers have to achieve the fine balance between the candid, professional desire to develop and expand services and the ultimate demands and need to protect the public purse and to limit budgets. Consequently representatives of the government ministries argued that since they were not involved in the initial establishment and development of the spiritual care programs, they are not sure now that they will be able to commit to the continued implementation of the programs if and when the initial funding for implementation comes to an end..

Many, however, expressed interest and willingness to participate actively in the planning and development of spiritual care and to serve on steering committees and discussion groups in the future. Evidently in the future, it will be worth inviting government policymakers to be involved in the development processes at an earlier stage and to persist at all stages of development of the programs.

Funding of Spiritual Care

One major theme was about allocating funding to spiritual care. Even the directors of the two hospitals in which spiritual care programs are currently implemented and appreciated said that it would be difficult for them to employ spiritual care providers on the hospital's regular budget.

The other directors described the development of spiritual care as a very significant challenge to the budget. Healthcare and social service providers in Israel have limited budgets, which do not allow for expenditure on services that are perceived to be beyond the boundaries of medical or social intervention. Moreover, since little is yet known about spiritual care and there is currently no accreditation or professional qualification, it is too difficult to justify expenditure on such services. The directors thought that it would be difficult to convince donors, boards of directors, and the relevant government inspectorate that spiritual care would be a better choice than another form of treatment or care. There is no doubt that a study showing spiritual care to be effective could help change this attitude.

How to Successfully Integrate Spiritual Care into the General Health and Social Services System

Most of the stakeholders and managers – whether familiar with spiritual care or not – believe that this profession has to evolve gradually from the service providers, i.e., the bottom-up approach. Once the growth of spiritual care has achieved sufficient momentum, health and social service policymakers can become involved in a more comprehensive implementation.

Spiritual care is still at an embryonic stage in Israel. A mere three hospitals each have a single spiritual care provider and a handful of institutions implement programs with spiritual care components. It is hard for the stakeholders to envisage how further programs can be funded when the need for spiritual care is still not recognized. They believe it is important to continue the current funding for these programs and to use them as a catalyst for generating greater interest from the wider community about the importance of spiritual care in health and social services. It would then be possible to envision the expansion of spiritual care into wider Israel society.

They also think it is important to be working closely with Ministry of Health in parallel to developing spiritual care services in hospitals and institutions. They consider that such a dialogue would allow major issues to be addressed, such as: whether there is room for an additional care giving profession on the hospital staff; what the likelihood is that such a staffed position would be approved; what the training demands should be; and what the different ways of engaging such a person could be.

Another important issue raised was the accreditation and professionalization of spiritual care providers. Stakeholders and policymakers feel that in order to integrate spiritual care fully into the health and social services, there needed to be professional training and official credentialing. All stressed the urgent need to take steps to ensure that spiritual care providers be included in the register of professions and given formal recognition in Israel. This would require a formal, professionally recognized training program that would be officially licensed in the same way as other paramedical professions.

Additional Considerations

The stakeholders and policymakers made the important observation that spiritual care programs are a powerful medium for targeting support to caregivers and families of patients or other

clients. Often the family and caregivers have to struggle with issues that are as challenging and difficult to deal with as those faced by the patients themselves. Therefore they thought that it was important, when developing and planning future spiritual care services, to consider the needs of the individuals surrounding and supporting the patient as well as the patients or clients themselves.

7.4 Conclusions

Although most of the directors, stakeholders, and policymakers interviewed are unfamiliar with spiritual care, they expressed positive feelings about what it could offer. However, they also expressed apprehension about the religious dimension of spiritual care and the potential conflict with members of other professions. There is strong agreement about the necessity to fully understand the meaning of spiritual care before making any decisions about whether to implement it. Concerns were expressed about funding and the competition for limited resources from other caregiving professions.

The two hospital directors we interviewed made an interesting observation about the importance of spiritual care in medicine. They believe that fundamental shifts are occurring in the medical world, which mean that it will not be possible to offer physical cures only, without considering the spiritual and mental wellbeing of the patient. Consequently, they consider the promotion and integration of spiritual care to be an inevitable – and positive – development in Israel's health and social service systems. To quote one of them: "I believe in the connection between body and soul, even if there is no evidence-based confirmation in empirical research. It is important that doctors know that the coping mechanisms of some patients with serious illnesses (whether preventive or curative) are likely to be linked to mental resources. Spiritual care is an unconventional method of care … with considerable potential to relieve suffering, anxiety, and painful feelings among terminal patients."

8. Conclusions: Future Directions for the Development of Spiritual Care in Israel

8.1 Introduction

In this section, we set out a possible framework for the future development of spiritual care in Israel. The ideas discussed are drawn from the findings of the evaluation of potential providers and policymakers for spiritual care in Israel, as well as current providers and recipients of spiritual care conducted by the Myers-JDC-Brookdale Institute. Based on these interviews, we suggest following two basic approaches as to how spiritual for care can be more fully implemented and integrated into the social and health systems of Israel:

a. Through consolidation and professionalization of spiritual care in Israel

b. By providing greater opportunities for stakeholders to become familiar and comfortable with the practice of spiritual care in Israel

The development of spiritual care in Israel, with the critical support of UJA-Federation of New York, has come at exactly the right time and fits in well with the current Israeli zeitgeist for the existential and spiritual dimensions of Judaism. The initial foray into spiritual care – through individual care, conferences, seminars, and workshops – has introduced thousands of people, both professionals and recipients of care, to a virtually unknown field.

8.2 The Future Implementation of Spiritual Care

This rapid exposure of Israeli society to spiritual care has been mostly due to the involvement of a few of deeply committed enthusiasts and to the funding they have received. These individuals are trained in a wide range of disciplines, with therapeutic experience and knowledge. However, none of them is formally trained in spiritual care. There are currently no fully accredited spiritual care training programs in Israel, but the consensus for the need of such programs is growing.

The first major theme drawn from the evaluation is that of developing and consolidating spiritual care programs that not only allow for the expansion of spiritual care provision, and but also lead to official recognition from various government agencies. Such a process needs to be accelerated so that spiritual care can be automatically included service in the health and social system in Israel.

The second related theme is the continued exposure of spiritual care to directors, policymakers, and stakeholders in the health and social services in Israel.

Based on the interviews and the evaluation of spiritual care services, we have been able to discern several potential directions, within the context of these two themes, for the future development of spiritual care provision:

- Establishing spiritual care as a profession in Israel
- Development and implementation of a system of placement and supervision of spiritual care providers
- Short-term approaches for increasing the number of recognized (and officially certified) spiritual care providers
- Developing a higher public profile for spiritual care
- Recognition by government agencies

8.3 Establishing Spiritual Care as a Profession in Israel

Establishing spiritual care as a profession that is similar to other recognized allied medical health professions and therapeutic vocations should be a primary task involving the following activities:

- Constructing a curriculum for the training of spiritual care providers that is suited to the Israeli culture and also meets the academic standards required by such programs in other parts of the world.
- Finding people with academic and professional credentials to be on the steering committee designing the curriculum and implementing the training program(s). Such a committee should also have a wide representation of experienced professionals from the field.

- Identifying one or more recognized academic institutions in Israel that will express a willingness to develop the new course, accept the curriculum and award diplomas that are officially recognized in Israel.
- In the context of developing a training course(s), we suggest that it would be helpful to create in one of the organizations a job that is specifically directed at introducing this new discipline and promoting the development of the profession and the field.

8.4 Development and Implementation of a System of Placement and Supervision of Spiritual Care Providers

In addition to developing spiritual care education, there needs to be a concomitant system of placement, supervision, and counseling for graduates to gain practical experience. We see a twofold purpose for placements. First, the practicum is an essential component of any training for work with patients. Second it is a good method for promoting spiritual care in the health and social service system in Israel. The practicum will provide those institutions that have little or no knowledge of spiritual care provision to see it at work and to understand the important role it can play in patient care.

A placement system of this kind would have three primary roles:

- Identifying potential places of employment for spiritual care providers, negotiating, and placement
- Supporting the spiritual care students and new graduates when they start work and providing supervision and counseling
- Providing information to directors of hospitals, departments, and services who show willingness to introduce spiritual care and disseminating the subject to those unfamiliar with it.

We found that once institutions had been introduced to spiritual care and discovered its value and benefits, they were much more likely to find funding for such programs in the future. However, without this initial experience, most institutions are unlikely to fund such an innovative program or even provide funding for trainee placements. This represents a core challenge for the expansion of spiritual care in Israel. We believe that this will become much less of a problem once spiritual care has a more significant profile in the system through more providers in the field.

8.5 Short-term Approaches for Increasing the Number of Recognized (and Officially Certified) Spiritual Care Providers

In addition to the medium- to long-term approach of developing training courses with accredited curricula, it may also be possible to increase the number of spiritual care providers in Israel in the short term, through the following activities:

- Increasing the number of participants in Clinical Pastoral Education (CPE) courses in Israel by running more courses throughout the year.

- Providing fellowships to Israelis for spiritual care training in the United States. This means that within a short time, a significant cadre of Israeli spiritual care providers could be active within the health and social service system in Israel.
- Devising an accelerated individual training program for the currently small number of people involved in promoting the field in Israel. This process would significantly help the development of the profession, since these people are known and respected and they have initiative and vision and are already performing the work now, without formal professional recognition.

8.6 Developing a Higher Public Profile for Spiritual Care

We have already noted that very few directors, policymakers and other key stakeholders in Israel's health and social systems have knowledge and experience of the spiritual care profession. There are mixed reactions to the idea of spiritual care, but certainly there is a need to raise its profile at every level of the health and social service system. This would be important to:

- Devise a public relations strategy for spiritual care that is designed to introduce professionals and decision-makers in Israel with little knowledge or experience of the field to its value and potential benefits and to continue the work of introducing spiritual care to interested professionals.
- Implement a few demonstration projects to promote a wider acceptance of spiritual care. Such programs would facilitate broad exposure of the discipline, constitute a model for others, and serve as way of disseminating information about the role of the spiritual care provider. Naturally, such demonstration programs would also have to be budgeted and funded for several years by donations and grants.

8.7 Recognition by Government Agencies

There is a consensus that the most appropriate way of getting professional recognition from the Ministry of Health and the Ministry of Social Affairs and Social Services is from a grassroots development of spiritual care (meaning a bottom-up approach). This is about creating the need for spiritual care in the various social services and health institutions in Israel so that the various government agencies will have to formally recognize the field. It is unlikely that these government agencies will take the initiative on spiritual care until it is shown to be a useful part of the system.

8.8 Conclusion

There has been a remarkable growth of spiritual care programs in Israel within a very short space of time. In just three years, thousands of individuals, professionals and recipients of care have been exposed to the spiritual care framework. UJA-Federation of New York's Caring Commission and the Health, Healing and Hospice taskforce have been instrumental in the development of spiritual care in Israel with their knowledge and expertise, as well as their generous funding of numerous programs.

Among the directors of programs and institutions, rabbinical students and care provision trainees, and the recipients of spiritual care, there is a genuine excitement about the potential value and impact of spiritual care. It is clear that for the people currently involved, spiritual care has thus far been implemented in an appropriate manner that fits within the Israeli social context.

Spiritual care has begun to establish roots within the health and social service system in Israel, but it is still at an early stage of development. The implementation process needs to continue apace, with care and consideration about the best way for spiritual care to be accepted by the health and social services establishment. We have set out some ideas to facilitate fuller implementation of spiritual care and to build on the impressive start that has already been made.

Spiritual care provides the potential for shared existential connections and meeting places among the sheer vibrancy and diversity of Israeli society. It needs to be an integral part of health and social services. Many of those already involved in the implementation of spiritual care feel that the language of spiritual care needs to enter the health and social service culture of Israel, and that all individuals, irrespective of religious or cultural affiliation must be provided with a way to express their fears and hopes during times of illness and distress.

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Appendix: Examples from the "Toolbox" and the Training Program

Rosh Hashana

May the year which begins now be beautiful and different.
Naomi Shemer

******

Open the gate for us
At the time of the locking of gates,
For the day has turned

The day will turn
The sun will come and turn
Your gates we will enter
Neilla Prayer – From the Yom Kippur prayer book

******

May one year, with its curses, come to an end while another year, with its blessings, begins
"Little Sister" liturgical poem for Rosh Hashanah

******

Blessed are You, who casts the bonds of sleep upon my eyes,
and slumber upon my eyelids.
May it be Your will, that You lay me down in peace
and rise up in peace.
Let not my thoughts, or evil dreams, or ill-imagining confound me;
But suffer my bed to be tranquil in Your presence
and may You illuminate my eyes lest I die in sleep,
For you illuminate the pupil of the eye.
Blessed are You, Who illuminates the entire world with His glory.
Night prayers before retiring

******

I trust the rain to keep falling down
Let the night last, don't fear my love,
It is always the darkest before dawn.
Shalom Chanoch

A Song of Ascents
I will lift up mine eyes unto the mountains: from whence shall my help come?
My help cometh from the LORD, who made heaven and earth.
He will not suffer thy foot to be moved; He that keepeth thee will not slumber.
Behold, He that keepeth Israel doth neither slumber nor sleep.
The LORD is thy keeper; the LORD is thy shade upon thy right hand.
The sun shall not smite thee by day, nor the moon by night.
The LORD shall keep thee from all evil; He shall keep thy soul.
The LORD shall guard thy going out and thy coming in, from this time forth and for ever.
Psalms Chapter 121

******

When is the darkness?
At the first rise of morning
As the moon sets,
the stars are gathered in
And the constellations go on their way.
There is no greater darkness than that hour.
And at that hour The Holy Blessed One raises the morning from out of the darkness
And lights up the world.
Midrash Yalkut Shimoni

******

Brotherhood
I am a man: my days are short
And the night is vast.
But I lift my gaze:
The stars are writing.
Without understanding I grasp:
I am a writing myself
And right this moment
someone is spelling me
Octavio Paz

******

May one year, with its curses, come to an end
While another year, with its blessings, begins
"Little Sister" liturgical poem for Rosh Hashana

I see, said Ateryu.
"And what about those three gates?"
Angiwak got up, folded his arms on his back and started pacing to and fro.
"The first" he started lecturing, "is known as the great riddles' gate". The second is the magic mirror' gate. And the third is 'the no key gate'…"
"Strange" Ateryu cut into his words. "As much as I could see, there was nothing behind that stone gate, except for an empty plane. Where are the other gates?"
"It is very complicated: the second gate is there only after you've passed the first gate, and the third isn't there until you've put the second gate behind you."
"Let's say you have succeeded passing the first gate, and only then the second gate will exist there for you, a gate that is open and closed, perhaps it will be better to say that it's not closed and not opened, what we have here is a big mirror or something like it. When you stand facing it you see yourself. But not as you would see in a real mirror. What you see is your true inner nature. If you go through it, you must – if one could say so – get into your self."
"And what about the third gate?"
"This is where things get really complicated! Because, you see, 'no key gate' is closed, simply closed. Full stop! But if someone succeeds in forgetting all intention and giving up wanting – the gate opens up for him by itself."
Michael Ende – The NeverEnding Story (adaptation)

******

Bless for us this year
and its yield, of all kinds – make it good.
And provide dew and rainfall, a blessing upon the face of the earth;
Quench the thirst of the world, satisfying everyone with your goodness.
Fill our hands with your blessings, with the rich bounty of your gifts.
Protect this year, saving it from any bad thing,
from all kinds of destruction and calamities.
Grant it positive hope and a peaceful conclusion.
Have mercy and compassion upon it and upon its entire yield and its fruits,
And bless it with the rain of goodwill, of blessing and inspiration.
May its conclusion be in life, satisfaction and peace,
as the good, blessed years.
From the Amida prayer

******

Open the gate for us
At the time of the locking of gates,
For the day has turned
The day will turn
The sun will come and turn
Your gates we will enter

Passover

For, lo, the winter is past, the rain is over and gone; The flowers appear on the earth.
Song of Songs

******

And from the sun's energy, the earth raises fruits
Bamidbar Raba

******

We have also included three haiku poems, translated from Japanese about the blossoming of the plum and how you need your heart, as well as your nose, to appreciate it.

******

One who goes out in springtime and sees trees budding, should say: "Blessed be He who left nothing wanting in His world, and created therein fine creations and fine trees, so that people may take pleasure in them"
Talmud, Brakhot 43

******

In our garden the plum is flowering
From the beginning of Adar we expect the blossoming
that the plum in our garden will blossom in
and its buds explode in white
sending calls of spring all around them.
Until evening, when the festival rests on our heads,
its branches, adorned with songs' of songs
together with the voice of the turtle on our window
gurgling a stream of youth.
Amir Gilboa

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In every generation, indeed in every day, a person ought to regard himself as though he has today become extricated from Egypt.

For it is necessary that there be an Exodus from Egypt every day, since each day and each period constitutes a unique Egypt (*mizrayim*). Each day, a person finds himself in a specific kind of constraints (*mezarim*) and limits – and it is from these that he must extricate himself.
Sefer Hatanya and Rav Steinzaltz

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"The deeds speak within the soul"
Rav Kook

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Speaking within my deeds, shouting by them
To you,
You who truly pities,
Who sees me day by day
All bent
And rising
I whom fear rules,
That is walking from slavery to freedom
every day
anew
Tanya Hadar

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Hametz in the Heart:
When Rabbi Israel of Wiesnitz, with his servant, was on his way to search for the Hametz, he stopped and opened his cloak. Uncovering his breast, he said: "You know that the real Hametz is the Hametz in the heart – search me here!

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b'Ruakh – by Spirit

Spiritual Care and Training

Jonathan Rudnick

Psalm 23

1. *A Psalm of David:*
   Adonai is my Shepherd;
   I lack nothing.
2. In the greenest pastures
   Adonai lays me down;
   Alongside still waters
   Adonai leads me.
3. Adonai renews my soul, my life;
   Adonai guides me in the paths of *Tzedek*/Right,
   for the sake of the Divine Name.
4. Even if I should walk
   through a valley of deepest darkness
   I fear no evil
   for You are with me.
   Your rod and Your staff --
   these comfort me.
5. You spread before me a table
   in full view of my enemies;
   You anoint my head with oil;
   My cup overflows!
6. Only *Tov*/Goodness and *Hessed*/Lovingkindness
   will pursue me
   all the days of my life;
   I shall dwell in the house of Adonai
   for many full, long years!

translation Rabbi Simkha Y. Weintraub, CSW (c) 1995

"not by might, not by power, but by My spirit"

ברוח
תמיכה רוחנית והכשרה

תהילים פרק קכא

א שִׁיר, לַמַּעֲלוֹת:
אֶשָּׂא עֵינַי, אֶל-הֶהָרִים-- מֵאַיִן, יָבֹא עֶזְרִי.
ב עֶזְרִי, מֵעִם ה'-- עֹשֵׂה, שָׁמַיִם וָאָרֶץ.
ג אַל-יִתֵּן לַמּוֹט רַגְלֶךָ; אַל-יָנוּם, שֹׁמְרֶךָ.
ד הִנֵּה לֹא-יָנוּם, וְלֹא יִישָׁן-- שׁוֹמֵר, יִשְׂרָאֵל.
ה ה' שֹׁמְרֶךָ; ה' צִלְּךָ, עַל-יַד יְמִינֶךָ.
ו יוֹמָם, הַשֶּׁמֶשׁ לֹא-יַכֶּכָּה; וְיָרֵחַ בַּלָּיְלָה.
ז ה', יִשְׁמָרְךָ מִכָּל-רָע: יִשְׁמֹר, אֶת-נַפְשֶׁךָ.
ח ה', יִשְׁמָר-צֵאתְךָ וּבוֹאֶךָ-- מֵעַתָּה, וְעַד-עוֹלָם.

A Song of Ascents
I will lift up my eyes unto the mountains:
From where shall my help come?

My help comes from God,
Maker of heaven and earth.

He will not allow your foot to be moved;
your guardian will not slumber.

Behold, the guardian of Israel does not slumber or sleep.

God is your protector;
God is your shade;
standing on your right-hand side.

By day the sun shall not strike you;
nor the moon by night.

God will guard you from all evil;
and will watch over your soul.

God will guard your going out and your coming in,
From this time forth and for ever.
(Psalm 121)

"לא בחיל ולא בכח כי אם ברוחי..." (זכריה ד':ו')