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### Shema, Vidui, Yivarechecha: What to Say and How to Pray with Jewish Patients in Chaplaincy

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# **Shema, Vidui, Yivarechecha: What to Say and How to Pray with Jewish Patients in Chaplaincy**

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*A 90-minute focus group was conducted with five male and two female Jewish professional chaplains from Reform, Conservative, and Orthodox backgrounds. This study describes and discusses eight principal themes that emerged from the focus group: (a) the identity, (b) role, and (c) practices of a chaplain; (d) Jewish chaplaincy prayers; (e) practices for chronic versus acute care; (f) patients' reactions to the chaplain's gender; (g) general and spiritual interventions; and, finally, (h) challenges in chaplaincy.*

**KEYWORDS** *chaplaincy, Judaism, pastoral care, religion*

## INTRODUCTION

Judaism has a long tradition of involvement in health care in the United States (Flannelly et al., 2006), and a far longer tradition of tending to the needs of

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the sick. Indeed, the Jewish practice of *Bikkur Holim* (visiting the sick) dates directly back to early rabbinic times of the first millennia, and there is evidence that it dates back to the Bible itself (Sheer, 2008).

The role of the rabbi has changed over the centuries. The current role of modern American reform, conservative, and orthodox rabbis has been largely influenced by the role of the minister. As such, rabbis and other Jewish professionals have become more involved in pastoral care both within and outside their congregations, including professional chaplaincy.

Professional chaplaincy was first officially recognized as a healthcare field by the American Protestant Hospital Association (APHA) in 1946 (History Corner, 2010), and by 1965, clergy from nearly two dozen Protestant denominations were actively involved in chaplaincy (Plack & Reeves, 1966). One of the earliest professional chaplain associations was the Association of Mental Health Chaplains (AMHC), which was founded in 1948. In 1968, the AMHC began certifying chaplains on an interfaith basis, including Catholic, Jewish, and Protestant chaplains (History Corner, 2010). Coincidentally, a national survey pertaining to pastoral counseling and other practices among rabbis was published that same year in the *Journal of Pastoral Care* (Gilbreath & Hoenig, 1968). The survey found that rabbis placed considerable importance on providing pastoral counseling to their congregants and on the education and training that is needed to do it successfully. Reform rabbis, in particular, placed a very high value on pastoral counseling and were more likely than rabbis of other denominations to have special training to prepare them as counselors. The National Association for Jewish Chaplains (NAJC) was founded in 1989 to target the development of rabbis, cantors, and other Jewish professionals as chaplains (About Us, 2010).

The specialized education and training that clergy receive to become chaplains is termed Clinical Pastoral Education (CPE), which was developed by Reverend Anton Boisen and other Protestant ministers. The CPE's focus on Christian traditions and practices posed problems for rabbis, rabbinical students, and other Jewish professionals entering CPE programs (Silberman, 1986, 1989), and some of these issues are still unresolved (Taylor & Zucker, 2002).

Although other articles have offered a Jewish perspective on pastoral care (Shulevitz & Springer, 1994), few have examined the views of Jewish chaplains about their own practice of pastoral care. The present study is intended to obtain first-hand knowledge from professional Jewish chaplains about the specific pastoral care they provide to patients.

## METHODS

A 90-minute focus group was conducted with five male and two female Jewish professional chaplains. Two of the male chaplains were from Orthodox backgrounds, two were from Conservative backgrounds and the fifth

male chaplain was from a Reform background. One of the female chaplains was from an Orthodox background and the other female chaplain was from a Reform background. The rabbis had worked in diverse settings before and during their work as chaplains, including congregations, the military, inpatient and outpatient hospital settings, and nursing homes.

The focus group was led by a HealthCare Chaplaincy postdoctoral researcher, who introduced the following questions pertaining to: (a) whether prayer is a standard ingredient during a visit with a patient; (b) protocols for acute versus chronic patients; (c) protocols for patients who spend three or more days per week at a hospital; (d) which “general” or “spiritual” interventions the chaplains typically employ in a visit (see Appendix A); (e) the greatest challenges as a chaplain; (f) the best experiences as a chaplain; and (g) key mentoring lessons for a new chaplain. Two trained researchers independently read the transcript of the focus group to extract the major themes expressed by focus-group participants. Each researcher recognized the themes introduced by the moderator, specific subsets of these themes, and one to two separate themes that arose during the discussion of these topics. The themes presented in the Results were reached by consensus.

## RESULTS

A variety of themes emerged from the focus-group data. In all, the Jewish chaplains discussed eight major themes during the session: (a) the identity, (b) role and (c) practices of a chaplain; (d) Jewish chaplaincy prayers; (e) practices for chronic versus acute patient care; (f) patients’ reactions to the chaplain’s gender; (g) general and spiritual interventions; and, finally, (h) challenges in chaplaincy.

### Identity, Role, and Practices of Chaplains

In discussing the identity and role of the chaplain, one chaplain expressed how he enters a patient’s room as a “representative of G-d<sup>1</sup>” and/or as a “representative of the Jewish people.” He believed that this representation allowed his visit to be relevant to a variety of patients. With respect to responsibilities or best practices for chaplains, various chaplains discussed the practice of chaplaincy by describing the steps they take in a typical visit. A female chaplain explained how she conducts a variety of assessments upon entering the patient’s room: she assesses “the physical and mental condition of the patient,” “the amount of social support the patient has,” “the spiritual needs of the patient,” and evaluates “the level of loneliness, sadness and depression” in her patient. Beyond the initial assessments, she described how she “offers a tailor-made prayer or customized prayer” in response to what her patient has expressed. Another chaplain discussed how he often

contacts the congregation on behalf or by request of the patient. In addition, he said that he will typically offer a *Misheberach* (healing prayer) while in the patient's room.

Another chaplain discussed the importance of "getting the patients to trust you." He prioritized the need "to try and understand the feelings of a patient and to try and do something for them [the patients]." He suggested that "even a small thing like prayer helps a patient understand that you are there for them" and "patients will rarely turn a prayer offer down." Moreover, he discussed the crucial importance of "sitting down with the patient eye-to-eye." Overall, he explained that "offering prayer and eliciting emotions and feelings from patients" were key features for best chaplaincy practice.

A third chaplain discussed the importance of "having patience with patients." He relayed the story of a patient who was highly resistant to his visits, but eventually developed a strong relationship with him. He discussed the importance of persistence and placing yourself in the shoes of the patient. Furthermore, he recommended singing with patients since many of the patients in his hospital cannot speak. In fact, a variety of nurses and parents who witnessed his singing and rapport with Jewish children and adolescents requested that he come visit their non-Jewish patients and children. Finally, he shared a story of a 19 year old African American patient whom he had visited when she was a child. Years later, she still looked favorably upon him and averted her gaze in a playful manner when she saw him in the hospital.

All of the chaplains identified empathic and effective listening as the number one best chaplaincy practice. Effective listening, empathic listening, and placing oneself in the patient's shoes were all essential aspects to each chaplaincy visit. In addition, one chaplain cautioned that the worst thing you can do in a patient's room is to "look at your watch." One male chaplain explained that, ironically, it is the caretaker of the patient who often becomes the "main person you care for" in a chaplaincy visit. Another male chaplain concurred with this notion. Often the caretakers are neglected due to the focus on the patient by the chaplain or other staff; yet, it is often the caretaker or family members of the patient who require significant assistance, as well.

### Prayers in Jewish Chaplaincy

The majority of chaplains indicated that prayer plays a vital role in their visits with patients. *Shema*<sup>2</sup> was the most commonly discussed prayer, and the prayer, which appeared to have the greatest value for patients of all denominations in Judaism. One male chaplain remarked that the "Shema is useful because it's so common for most Jews; it allows them to interact with me, and it elicits their interest." Another male chaplain suggested that the "Shema transcends everything." A female chaplain also viewed the *Shema* as a "useful prayer."

The *Vidui* (confessional prayer)<sup>3</sup> was the most controversial prayer discussed during the focus group. The chaplains appeared to be less concordant

with respect to their perceptions as to whether or not the Vidui was appropriate to say with a patient. One male chaplain suggested that “he might do the Vidui” with a patient, while another male chaplain commented that “I have done it several times when I have been asked to do it.” A third male chaplain explained that “it depends on the visit, you might be asked by the family to recite the prayer.” The two remaining male chaplains were opposed to saying the Vidui with patients: the first “felt uncomfortable saying the prayer” with the patient while the other chaplain “did not feel right” conducting the prayer with a patient. A female remarked that much of this discomfort might be due to the confessional nature of the Vidui prayer; thus, making it appear more like a Christian rather than a Jewish tradition. Finally, a female chaplain explained that she often says the *Yivarechecha*<sup>4</sup> with patients or spontaneous prayers with patients if their needs are specific.

### Chaplain’s Gender

There appeared to be some discordance among the chaplains as to whether or not observant male patients are agreeable to visits from female chaplains. A female chaplain suggested that her “patients are not resistant to a visit by a young woman.” Similarly, the other female chaplain remarked that “Lakewood and Brooklyn patients [observant Jewish patient populations] never objected to me as a chaplain.” Interestingly, it was only a male chaplain who suggested that “[traditional and observant] Jews don’t want female chaplains” to visit.

### Chronic versus Acute Patients

The chaplains suggested that there may be some distinctions in chaplaincy care with respect to chronic and acute patients. The majority of chaplains agreed that speaking to the family was a top priority in chronic cases or, additionally, when a situation might progress from an acute to a chronic state. One chaplain commented: “often the patient comes in acute and turns chronic. It’s very useful to talk to the family about chronic being a new situation and to discuss how to adapt to it.” Another explained how important it was to allow people “to say things that are weighing them down. This is part of chronic.”

Two other chaplains remarked at how important it was to listen to the family and to speak to each family member individually in cases where there is a transition between chronic and acute care; cases that frequently involve the elderly. A chaplain discussed how one could progress from a chronic to an acute state: “a woman asked to speak with the chaplain because her mother took a turn for the worse. Things turned around in 12 hours from ambulatory to very bad.”

In addition to the difficult nature of discussing changes from acute to chronic states and vice versa, the two female chaplains emphasized that

working with patients in chronic situations affords the chaplain more time to get to know and establish a rapport with the patients.

As one female chaplain remarked “the patients are very happy to see me and talk to me. I find it helps if people know you; you can develop rapport.” The other female chaplain suggested that you might be able to participate in “ethical consultation” and “theological development” with chronic patients.

### General and Spiritual Interventions

After a list of general and spiritual interventions (see Appendix A) was distributed to chaplains, the chaplains discussed which general and spiritual interventions they most commonly employed with patients. One female chaplain discussed how useful the list of general and spiritual interventions was for her. One male chaplain indicated that “emotional enabling and empathic/active listening resonate most with me.” Another male chaplain suggested that “life review is not a part of our initial visit.” He predicted that chronic patients would not want life review, whereas patients who are dying might be more interested in life review.

### Challenges of Chaplaincy

The focus group concluded with a discussion of some general challenges during chaplaincy visits. A female chaplain commented on how difficult it is to have a profession wherein you “have no clear idea about what will happen each day.” However, she described chaplaincy as “a great experience.” A male chaplain suggested that it is often difficult to determine how best to handle a family situation, wherein the family members do not agree on how to contend with an end-of-life decision. He offered a specific example of a father of four children who came into the hospital. The children wanted to be involved in decision-making pertaining to their father’s care. The chaplain described the challenge of establishing a unity of purpose among the family members about their father’s looming death. Only one of the family members was observant and she was the member seeking the rabbinical advice from the chaplain. After much discussion and consultation with the chaplain, the family eventually agreed on a course of action.

## DISCUSSION

Overall, the chaplains agreed on a variety of best practices and techniques in chaplaincy, but they were more discordant with respect to whether or not it is appropriate to recite the Vidui prayer during a visit, whether or not to recite spontaneous rather than solely traditional or liturgical prayers, and

whether having a female Jewish chaplain visit is problematic among more traditional or observant Jewish patients. The chaplains all agreed that empathic and active listening were key features to effective chaplaincy practice and that contending with family dynamics was an integral aspect of chaplaincy care, especially in transition periods between acute and chronic care states of the patient.

The discomfort that a few Jewish chaplains described with respect to reciting the confessional Vidui prayer with a patient aligns with Silberman's (1989) comments that Jews typically recite the Vidui confessional prayer only during the High Holy Days and fast-days. This stands in sharp contrast to Christian liturgies, which include personal and communal confession. While a few chaplains remarked that they would recite the Vidui at a patient's request or in certain circumstances, others felt more uncomfortable with this recitation. There is some evidence that liberal Jews are now engaging Vidui; recapturing it from being lost as a theological resource. To the degree that this is true, some chaplains argue that it would be helpful for chaplains to offer the Vidui for the benefit of their patients and residents despite their own potential discomfort with the confessional prayer.

Another rabbi explained that the part of the Vidui prayer wherein the patient's death is perceived as an atonement for his/her sins in life may be particularly problematic or may cause discomfort among chaplains or clergy-persons who are interacting with a patient at the end of life. Confession has a Christian connotation to it. He delineated two strands of thought with respect to G\_d and healing: (1) a judging G\_d who holds us responsible for our sins and afflicts us; and (2) a loving and kind G\_d, who weeps at the death of the righteous. Since his theology aligns more closely with the latter (a loving G\_d), he feels that G\_d does not afflict us, but rather helps fortify us when our imperfect bodies break down. He further suggested that chaplains and visitors serve as representatives of the Jewish community to remind the patients that, in addition to G\_d, they have numerous individuals who care for them and are praying for their recovery.

With regard to spontaneous or custom-made prayers as opposed to traditional prayers, one chaplain indicated that she offers a tailor-made prayer following an initial physical and spiritual assessment, whereas, the majority of others focused primarily on the traditional prayers with patients, including: the Misheberach, the Yivarechecha, Shema, and Vidui.

A variety of chaplains noted that the Shema was a particularly important prayer to recite, since many Jewish patients appeared to be familiar and comfortable with it. On the other hand, one might be cautious reciting the Shema prayer, since it may signal to some patients that their life may be in a tenuous state. Many Jewish students may have learned in religious school that their religion invites them to recite the Shema prayer before they die.

Yet, in a provoking paper, Shulevitz and Springer (1994) suggested that it is important to introduce familiar prayers (like the Shema) from

the *Siddur* (a Jewish Prayer book), rather than presenting passages from more esoteric rabbinical texts. Even a minimal familiarity with a text may provide patients with the necessary link to connect them to a theology rooted in their own experience, which would be framed by still-developing rabbinic theological concepts. She explains that accessibility is integral to Jewish pastoral care and that chaplains must utilize common language to engage patients rather than utilize language that is too removed from the patients' respective theological experiences. Similarly, Taylor (2005) suggests that Jewish prayer need not be in Hebrew, but rather in a language that the patient understands, since the optimal way to reach out to G\_d is through a prayer of the heart.

Moreover, the more common focus on traditional/liturgical prayers among Jewish chaplains—as opposed to custom-made prayers—may be unsurprising since a variety of rabbis allude to the foreign notion of a spontaneous expression of petition or thanksgiving in Judaism (Silberman, 1989, 1986). However, contrary to the popular opinion that custom-made or intercessory prayer is primarily Christian or foreign to Judaism, Taylor (2005) intimates that the Hebrew Bible and Judaism have a long-standing history of custom-made, verbal intercessory prayers (i.e., Abraham and Abimelech, Hagar and G\_d, Moses and G\_d, and prayers of Hannah, Elisha, Elijah and Job to G\_d.). Taylor suggested that, through custom-made prayers, patients are shown that their words are important to G\_d, and they may be connected to G\_d in ways that fixed prayers may not achieve.

Taylor (2005) delineates five guidelines for pastoral caregivers to follow in creating custom-made prayers: (1) Ask for permission to pray with the patient; (2) Ask the patient to identify a spiritual or physical focus for the prayer (i.e., in his/her body or spirit); (3) Address G\_d and, specifically, identify the patient by name to assure the patient that the prayer is specifically for him/her; (4) Relate the person's specific plight and story to G\_d; and (5) Share the individual's specific hopes with G\_d. Taylor explains that in cases where the patient is facing a terminal illness or will likely not recover from his/her illness, a pastoral caregiver can still hope that G\_d will be compassionate and allow the patient to feel G\_d's presence. The chaplain's prayers can also offer the patient strength, endurance, courage, and relief from pain during his/her time of illness. Taylor suggests that the focus should not be on developing the most creative prayer, but rather on formulating an empathic and compassionate prayer. Finally, she reveals that when pastoral caregivers pray on behalf of the patients with the words "the patients have provided," they will know you have heard them and this will help them to "feel seen and heard by G\_d" (Taylor, 2005).

The last area of dissension was whether or not women would be accepted as chaplains among more traditional and observant Jewish patient populations. Interestingly, the female chaplains (one Reform and one Orthodox chaplain) both remarked that they did not feel that their gender

was an issue of contention among more observant Jewish patients, whereas, an Orthodox male chaplain suggested that Jewish Orthodox male patients may express discomfort with receiving a visit from a female Jewish chaplain. Paradoxically, one of the authors (BT) suggested that some observant male patients may especially welcome the counsel of a female chaplain since there may be less of a chance that their discussion will find its way into the community. She claims that she does her best work with the ultra-Orthodox at night when there is less of a risk that individuals from the patient's community will visit.

The discrepancy between men and women's perceptions may be due in part to the more nascent status of chaplaincy in Judaism and to the fact that the term "chaplain" itself does not have a long-standing history in Judaism. Moreover, Orthodox Jewish populations, who do not currently ordain female rabbis, may be surprised by the presence of a female Jewish chaplain in their room. They may not be cognizant of the fact that non-rabbinical Jewish professionals can serve as a chaplain and offer them spiritual care rather than provide them answers to Halachically-based (Jewish rules and regulations) inquiries. Since older research found that reform rabbis placed more emphasis on counseling and pastoral visiting (Gilbreath & Hoenig, 1968), Orthodox patients may have received less exposure to pastoral care and counseling from their Orthodox leaders.

Today, however, more and more seminaries from all Jewish religious denominations are developing required or strongly suggested courses in pastoral care and counseling for rabbinic ordination and cantorial indistiture. The same is true for schools of social work and other healthcare professions. Taylor and Zucker (2002) allude to Abraham Joshua Heschel's (1955) conceptualization of Judaism as a "theology of deeds," rather than to a religion based solely on beliefs and to his teachings that: "A Jew is asked to take a leap of action rather than a leap of thought." For this reason, one might assume that some Jewish patients may be more hesitant or may feel more discomfort in discussing their beliefs with a chaplain, since they are more comfortable discussing actions than beliefs.

Finally, while the chaplains may have differed somewhat in their opinions of the aforementioned topics, all of the chaplains agreed that empathic and active listening and contending with family dynamics were key features of effective chaplaincy practice. Some rabbis have related two of the ten spheres of the Jewish mystical text of the *Kabbalah* to healing; *Hesed* (love/kindness) and *Gevurah* (strength). The *Hesed* teaching suggests that chaplains must listen and offer love and empathy, and usher the immanent G\_d with them into the room and into the relationship with their patients. Rabbi Nachman of Breslov (1772–1810) delineates the importance of this love and empathy by sharing a parable of a prince who acted as a frog and would only transform back into a prince once someone empathized with his state and understood him, at his level. In this manner, the chaplains'

endorsement of empathic and effective listening as a key ingredient to chaplaincy aligns closely with the *Kabbalistic* notion of *Hesed*, love and empathy.

The *Gevurah*, however, relates more closely to reminding the patient of his/her power, integrity, and uniqueness. Chaplains who assess the patient's practical needs, and empower and support the patient or the concerned family members are arguably practicing aspects of *Gevurah*.

Furthermore, with respect to key advisements from chaplains, the chaplains discussed the importance of sitting at an eye-to-eye level with a patient (rather than looking down at them) and never peering at one's watch. The chaplains suggested that patients read social-emotional cues or signals immediately from chaplains and visitors. Moreover, one chaplain suggested that it was essential to have "patience with patients;" to genuinely offer them time.

In addition to *Hesed*-based (social-emotional, empathic, effective listening) and practical *Gevurah*, there is a need for patients to find meaning in their lives. In the second half of his famous book, *Man's Search for Meaning*, Frankl (1946) introduces logotherapy, a therapy based on the notion that the primary motivational force of an individual is our will to find meaning in life. Frankl cites the words of Nietzsche: "He who has a Why to live for, can bear almost any How," to suggest that supplying individuals with a will to live will galvanize them into determining how to live (Frankl, 1959). From an existentialist perspective, he contends that we experience the freedom to find meaning in what we do, in what we experience, or in what perspective we take when we confront incontrovertible suffering. Logotherapy, or helping the patient find or reflect upon meaning in his/her lived life, may be integral to best practices of care at the end of life.

## NOTES

1. G\_d: Jewish tradition invites us to view the name of divinity as holy unto itself; therefore, it further invites us to use a substitute for the name of the divine. This manuscript is using: G\_d.

2. Shema: The Shema is usually identified as Judaism's main prayer. However, some would say that the Shema is not a prayer but rather the Jew's way of witnessing G\_d's existence and presence in the world. Perhaps, the reason the Shema takes on specific significance for the sick person is that it reminds him/her of G\_d's presence. As the Psalmist (Psalm 91) stated, "I (G\_d) will be with him in distress." Just as it is comforting to have a relative or supportive friend by one's side in life-threatening situations, so it is most reassuring to have G\_d there, as well.

3. Vidui: The Vidui prayer is said when a person is close to death. Just as it is cathartic, at such a time, to repair one's relationship with one's loved ones and friends, so too it is helpful to clear the slate with G\_d, who is aware of all of our personal spiritual failings as well as our attainments. The prayer ends with the *Shema*. Even when we are about to leave this world, we declare our loyalty to our Creator and Redeemer. We pray that just as his presence has been with us during our lifetime, so too may it continue to be present in the lives of our children, grandchildren, and descendants.

4. Yivarechecha: The Priestly blessing is first found in the Torah. Although, it was originally the prayer with which the *Kobanim* (priests) would bless the people, it eventually was borrowed by Jewish fathers and mothers throughout the world to be used as a parental blessing. The blessing, which proceeds from three to five to seven words, can remind a patient that his or her return to health will be accomplished in

steps. Each day the sick person can look forward to seeing some improvement in his/her situation. May G\_d bless you with future happiness, may he protect you, favor you, and grace you with understanding and patience, may he continue to show you his kindness and grant you peace.

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## APPENDIX A

General Interventions:

- a. Crisis Intervention
- b. Emotional Enabling
- c. Ethical Consultation/Deliberation
- d. Life Review
- e. Patient Advocacy
- f. Counseling
- g. Bereavement
- h. Empathic Listening

## Spiritual Interventions:

- a. Faith Affirmation
- b. Theological Development
- c. Performing a Religious Rite or Ritual
- d. Providing a Religious Item
- e. Offering a Blessing
- f. Praying
- g. Meditation
- h. Other Spiritual Support