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Soul Searching: Spiritual Care in the Japanese Hospice

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**SOUL SEARCHING:
SPIRITUAL CARE IN THE JAPANESE HOSPICE**

Timothy O. Benedict

A DISSERTATION
PRESENTED TO THE FACULTY
OF PRINCETON UNIVERSITY
IN CANDIDACY FOR THE DEGREE
OF DOCTOR OF PHILOSOPHY

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Abstract

This dissertation examines the religious dimensions of hospice care in contemporary Japan. Historically, Japanese religions provided a cosmological framework and a ritual repertoire for the end of life that helped assure dying persons of an auspicious rebirth, or escape from this world altogether. However, Japanese hospice patients today only rarely seek out these assurances—or at least not in ways that we might expect. As a result, religious professionals who work in Japanese hospice wards are expected to draw on a very different set of practices that align more closely with ecumenical and psychotherapeutic models by which the practice of spiritual care is legitimized in secular spaces.

This project, based on ethnographic fieldwork in multiple hospices across Japan, investigates through close observation of the actual practice of spiritual care, how hospice chaplains both draw on and resist these models, as well as what kinds of spiritual concerns Japanese patients actually express as they face the end. It also examines similarities and differences in how spiritual care is interpreted and conducted at Buddhist, Christian, and other hospices and relates these findings to a broader narrative of how Japanese religious groups are seeking out new vocational roles in modern medical institutions. By illuminating how spiritual care is conceptualized and practiced in Japan from both local and cross-cultural perspectives, this study provides new insights into contemporary Japanese religion by showing how religion is both shaping and being shaped within the medical context of the hospice. At the same time, it contributes a much-needed East Asian perspective to global conversations about the practice of spiritual care for the dying.

To Lardner and Mollie

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Conventions

- I have followed a modified Hepburn system for the romanization of Japanese terms. As much as possible, I have also included the *kanji* for key terms.
- All translations are my own unless otherwise noted.
- Japanese names are written in traditional Japanese order with the last name first.
- For reasons of confidentiality, the names of hospice workers and patients I interviewed are replaced with pseudonyms.

Chapter One

Introduction

“Your dissertation will be very boring.” An elderly Japanese hospice chaplain spoke these words to me in the summer of 2013. I was trying to explain that my research addressed the practice of spiritual care for hospice patients in Japan. He smiled and with a twinkle in his eye explained what he meant, “I’ve been working at this hospice for more than five years and I am still not doing spiritual care.” Then what was he doing? Little did I know at the time that he had put his finger on what would constitute a major challenge in my research: spiritual care in Japan does not always look like what we might expect.¹ This dissertation will explain why.

Since the inception of hospice care in Japan during the early 1980s, the hospice ward has become a key space in which Japanese religious groups, medical workers, and scholars have worked to produce new understandings of the role religion can play in medicine, as well as more broadly in Japanese society. In this dissertation, I draw on my ethnographic fieldwork in multiple hospices across Japan to unveil similarities and differences in how spiritual care is practiced and relate these findings to a broader story of how Japanese religious groups are seeking new vocational roles in public medical institutions. I also illuminate how spiritual care is conceptualized and practiced in Japan from both local and cross-cultural perspectives to show

¹ So what do “we”—meaning both this Japanese chaplain and myself—expect spiritual care to look like? While there is a wide range of definitions of spiritual care in international scholarship, it is typically understood as a type of care that addresses a patient’s “spirituality.” “Spirituality” itself was recently defined by an international group of healthcare practitioners as “a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.” See Pulchalski et al., “Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus,” *Journal of Palliative Medicine* 17, no.6 (2014): 646, accessed April 9, 2018, <https://doi.org/10.1089/jpm.2014.9427>.

how global discourses on the practice of spiritual care have been appropriated in Japanese contexts.

My project's title, "Soul Searching," refers to the three broad aims of this dissertation. First, it aims to show how "spiritual care" exemplifies the ways in which contemporary Japanese religious groups, and especially contemporary Buddhists, are engaged in an ongoing form of "soul searching" about their role in Japanese society. Statistical indicators of Japanese religiosity have consistently shown the declining importance of religion in Japan.² After the new religious group Aum Shinrikyō オウム真理教 carried out a sarin gas attack in the Tokyo subway system in 1995, many Japanese came to view religion with deep suspicion. In the aftermath of this attack, public trust in religious organizations eroded to an all time low, at about thirteen percent.³ Even in regard to death rites, which remain a traditional bastion of Buddhist influence, surveys continue to show a decline of religious beliefs and practices.⁴ In this context, a small but growing number of Buddhists came to see their involvement in hospice care as having the potential to combat longstanding negative stereotypes about the work of Buddhist priests as confined to funerary and memorial rites.⁵ For religious professionals more broadly, including Christian and members of New Religious groups, establishing new vocational roles in hospitals,

² According to one survey by the *Asahi Shinbun*, in 1978, approximately 39% of Japanese expressed some interest in religion. By 2003, this number had dropped to 23%. Surveys also indicate that, in 1980, only 32% of Japanese stated that religion "was not important" but that this number had grown to 58% by 2004. Ishii Kenji, *Dētābukku: Gendai Nihonjin no shūkyō* (Tokyo: Shinyōsha, 2007), 2, 21.

³ Robert Kisala, "Asian Values Survey," *Nanzan Bulletin* 23 (1999): 65. For more on the aftermath of the Aum incident, see Erica Baffelli and Ian Reader, "Impact and Ramifications: The Aum Affair in the Japanese Religious Context," *Japanese Journal of Religious Studies* 39, no. 1 (2012): 1-28.

⁴ For example, statistics from the Buddhist Sōtō Zen sect indicate that the number of death-related ritual services performed at its temples decreased by 18% between 1985 and 2005. Ian Reader, "Secularisation R.I.P.? Nonesense! The 'Rush Hour Away from the Gods' and the Decline of Religion in Contemporary Japan," *Journal of Religion in Japan* 1, no.1 (2012): 17.

⁵ Jonathan S. Watts, "Introduction," in *Buddhist Care for the Dying and Bereaved*, Jonathan S. Watts and Yoshiharu Tomatsu eds. (Somerville, MA: Wisdom Publications, 2012), 14.

a paradigmatic modern social institution, represented a potential avenue to dispel the suspicions and preconceptions many Japanese harbor towards organized religions. However, this soul searching is by no means new. Rather, I show how notions of spiritual care are embedded in a history, dating back to the late nineteenth century, of attempts on the part of modern Japanese religious groups to show the “healthy” role that religion can play in society.

The second aim of this dissertation is to show how the practice of spiritual care has prodded Japanese hospice workers and religious scholars to engage in a form of “soul searching”—quite literally— to determine the nature of “spirituality” and to define its relationship with patients’ bodies and psyches. One of the first questions that spiritual caregivers in Japan grapple with is, “what is spirituality?” In seeking to answer this question, Japanese hospice workers and scholars have produced a range of diagrams that seek to delineate the “spiritual” from the physical and psychosocial dimensions of hospice care, and outline the relationship between religion and “spirituality.” This discourse invariably presents “spirituality” as a discrete dimension of personhood, that resides in all patients, and that becomes “awakened” in the face of an existential crisis like death. However, I suggest that this reification of spirituality in hospice care discourse tends to ignore the diffuse ways in which hospice workers actually attend to the “spiritual” needs of patients in practice.

Finally, this dissertation aims to shed light on how Japanese hospice patients themselves engage in their own “soul searching” at the end of life. Japanese hospice patients only rarely articulate a “spiritual pain” that is centered on religious or existential concerns over the meaning of the life they lived, the meaning of their present illness, or whether their lives will have any meaning after death. Instead, most patients are often outwardly dismissive of questions about the meaning of their life or suffering, their relationship with God, guilt and forgiveness, and many

other “spiritual concerns” that commonly appear in Western literature on spiritual care.⁶

Instead, the primary concerns of Japanese hospice patients are often centered on the fear of becoming a burden on others and their inability to fulfill their social or familial responsibilities. I further show how the supposed presence of “spiritual pain” in terminal patients is often interpreted in ways that serve the needs of hospice workers, and especially chaplains, at least as much as the needs of patients.

In examining all these forms of “soul searching” I illustrate how spiritual care in Japan exemplifies the ways in which religion in Japan is both shaping and being shaped by care for the dying in modern medical spaces. Historically, Japanese religions provided a soteriological framework and a ritual repertoire for the end of life that helped assure dying persons of an auspicious rebirth, or escape from this world altogether. However, most Japanese patients today only rarely seek out these assurances. As a result, religious professionals who work in hospice wards as chaplains are expected to draw on a very different set of practices that align more closely to the ecumenical and psychotherapeutic models by which spiritual care is legitimized in secular spaces. I suggest that closer observation of the actual practice of spiritual care, which is still a very new phenomenon in Japan, can help us see some of the ways chaplains both draw on and also resist these models of care.

Ultimately, through my ethnographic fieldwork and interviews with hospice patients and chaplains, I seek to examine spiritual care *in situ*, to provide a richer understanding of the way contemporary Japanese approach the end of life and how spiritual care is provided by hospice workers in a manner that they feel will meet the patients’ most urgent end-of-life needs. In particular, I demonstrate how spiritual care in Japan often goes beyond helping patients vocalize

⁶ Pulchalski et al., “Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference,” *Journal of Palliative Medicine* 12, no. 10 (2009): 894.

and address their “spiritual pain” through counseling, religious support or being a sympathetic presence. More often, spiritual care is conducted in the margins of daily care, such as through special hospice events or even in the course of prosaic activities that chaplains and other hospice staff view as conduits for a kind of spiritual care that makes patients feel valued and appreciated at the end of life.

The study of spiritual care in Japan also has a broader, even global significance. Ongoing debates on “spirituality” in hospice care are part of an international conversation. More importantly, as a highly secularized non-Western modern nation, Japan represents an important case study in how spiritual care is provided to hospice patient populations that identify themselves as non-religious. In this way, this dissertation also seeks to contribute a valuable East Asian perspective to global conversations about the philosophy of spiritual care at the end of life.

This introductory chapter will begin by explaining the genesis of the research questions that led to this dissertation, which are based on my own prior experiences working as a hospital chaplain in Japan. I will then provide a review of scholarship on spiritual care in Japan and outline my own approach. This is followed by some background information on hospice care and religion in contemporary Japan that is pertinent to the study of spiritual care. Finally, I will provide a brief note on my research methods and provide summaries of the individual chapters.

Beginnings

The genesis of this dissertation can be traced to my work experiences as a chaplain at a large Presbyterian hospital in western Japan between 2009-2011.⁷ For two years, my job was to

⁷ Although I did not have any theological training or prior experience in spiritual care, I fell into this unusual job through an introduction arranged by a family friend, a former missionary who worked for many decades as a chaplain at the hospital.

visit inpatients in all the different hospital wards and listen to their concerns; lead chapel services, hospital concerts, seasonal events, tea gatherings in the hospice ward; and assist with a variety of other tasks. At the beginning, I basically stumbled through my work, anxious that I would say something horribly insensitive to a patient. For many patients, their hospitalization was the worst moment of their life. In some cases, it was the last week of their life. At such a time—as one hospice patient put it—“God feels really close.”

As I soon found out, however, spiritual care in Japan was a very ambiguous affair. Every day, I would first check in at the nurse station at the ward I was assigned to that month and then walk slowly from room to room to greet new arrivals while trying to project a friendly aura. My superior stressed in no uncertain terms the importance of avoiding anything that might disturb the treatment or recovery of patients. I was even advised to buy a pair of soft-soled dress shoes and to practice speaking in a slow, quiet voice so as to not annoy patients. When I reached a patient's room, I first softly called out a greeting from behind the curtain that separated each bed from others, or knocked gently on the sliding door of individual rooms, and then gingerly peeked in. In my hand, I held a folder that contained a welcome pamphlet, some postcards featuring colorful pictures of the stained glass windows in the hospital chapel, and a weekly hospital bulletin. The bulletin included a schedule of upcoming chapel services and other social events, an excerpt from a recent chapel message, along with trivia or inspirational and humorous quotes that would help patients pass the time.

As I parted the curtain to peek in, I would slip a welcome pamphlet, a postcard, and a bulletin out of my folder, extend them to the patient and say, “Please excuse me. My name is Benedict and I work in the chaplain's office. I have brought a few things for you to read.” If the patient was sleeping or not present, which was often the case, I would leave the materials on

their bedside table. If they were awake, I would ask, “How are you doing today?” (*Kyō no okagen wa ikaga desuka?* 今日のおかげんはいかがですか?). Most patients politely thanked me, and then I was on my way. A few let me know that they had no interest in conversing. Others welcomed the distraction, and we would chat for a few minutes. Depending on how the conversation went, I might make a note for a follow-up visit.

During these additional visits, we would talk about almost everything under the sun. Since my appearance betrayed that I was a foreigner, patients were often very curious about me; they commented on my Japanese speaking ability (I was born and raised in Japan) and related stories about family members who lived in or had visited the United States. Every so often we also talked about religion. Patients related how they had attended a Christian school or university, or, how even though their family was Buddhist, they enjoyed listening to the chapel talks that were broadcast to the hospital TV sets. But most patients would either preface or end their remarks by saying that personally, they were not religious.⁸

But if the patients were not religious, nor particularly interested in receiving religious support, why was I there? This also a question many patients had for me. When I introduced myself as a “chaplain” (*chapuren* チャプレン), many patients would query with a puzzled look: “Charlie Chaplain?” If our conversations went on for more than a few minutes, they also became concerned that conversing with me was taking me away from my “real” job. “Are you sure you don’t have any work to do?” I tried to explain that my job was to listen to their concerns (*nayami* 悩み) regardless of whether they were religious or not, but the majority of the patients—who had

⁸ As Ian Reader and other scholars have noted, although many Japanese claim to be “non-religious,” this does not mean that they do not participate in religious activities and behavior. This includes, but is not limited to, praying and making offerings at temples and shrines, venerating ancestors, going on pilgrimages, and performing Buddhist memorial rites. See Ian Reader, *Religion in Contemporary Japan* (Honolulu: University of Hawaii Press, 1991), 1-12.

never heard of such a thing as a chaplain or of even the word “spiritual care”—genuinely did not know what to make of me.

This sometimes made me, too, wonder what I was doing. More times than I could count, I emerged from visiting patients feeling humbled by their example and inspired by the ways they were coping with the pain and stress of their illness. But as an employee on the hospital payroll, this sometimes made me feel guilty. Was it right that I got to chat with patients all day and feel encouraged by the brave manner in which they dealt with their illnesses while the doctors and nurses did all the “real work”? Was I really helping patients in any way? As I began studying the practice of spiritual care in earnest, new questions arose. How was spiritual care in Japan different from elsewhere? In what way did the ambiguity surrounding my work, and the medical emphasis on patient outcomes, make it susceptible to efforts by chaplains to routinize and medicalize spiritual care in ways that would make it more quantifiable? How should spiritual care even be defined? These questions seemed particularly germane in the case of Japan, where hospital chaplaincy was still an emerging profession. What mechanisms were religious groups, medical professionals, scholars, and the media mobilizing to help promote a new class of spiritual care specialists? There was also the question of what kind of religious support patients might want. Considering that most Japanese are dedicated as children at a Shinto shrine, married in a Christian chapel, lead a mostly secular life, and will likely have a Buddhist funeral, what role, if any, did religion play for hospice patients at the end of life? These are some of the questions that lie at the heart of this dissertation.

Prior Scholarship

Prior scholarship on spiritual care in Japan can be divided into two overlapping categories. The first category includes clinical studies of spiritual care that are focused on patient case studies. This type of literature emphasizes the importance of spiritual care for hospice patients and sets forth a vision for how it should be practiced, often from a normative perspective having clinical implications. These studies include first-person accounts of hospice care, typically written by Japanese hospice workers that are aimed at a broad audience and explain the general features of hospice care by recounting touching or inspiring stories about past patients.⁹ These first-person narratives also explain what spiritual care is and why it is important, along with memorable stories of patients who benefited from this type of care.

This first category also includes more clinically oriented studies written to educate hospice workers. These studies are found in palliative care journals such as *Kanwa Kea* 緩和ケア and are used as textbooks for nurses or doctors. Titles of books like *A Guidebook to Spiritual Care*, *Practical Spiritual Care for Medical Workers*, and *The Spiritual Care that Nobody Explained to Me*, aim to make spiritual care understandable for hospice workers.¹⁰ Current or former chaplains who now work as educators engaged in promoting spiritual care or supervising spiritual care training programs also write many such studies. These studies often focus on defining or developing models of spiritual pain and spiritual care, spiritual assessment tools, case

⁹ Kashiwagi Tetsuo, *Shi ni yuku kanja no kokoro ni kiku* (Tokyo: Nakayama Shoten, 1996); Hosoi Jun, *Shi o osorenai de ikiru: Gan ni natta hosupisui no jinseiron nōto* (Tokyo: Inochi no Kotobasha Foresuto Bukkusū, 2007); Numano Naomi, *Iyasarete tabidachitai: Hosupisu chapuren monogatari* (Tokyo: Kōsei shuppan, 2002); *Tomo ni ikiru michi: Hosupisu chapuren monogatari* (Tokyo: Kōsei shuppan, 2004); *Manzoku shite shi ni iku tame ni: Hosupisu chapuren ga mita "oi" no sakebi* (Tokyo: Kōsei Shuppan, 2013); Fujii Rie and Fujii Miwa, *Tamashii no kea* (Tokyo: Inochi No Kotobasha, 2000).

¹⁰ See for example Tamura Keiko, Kawa Masako, and Morita Tetsuya eds., *Kango ni ikasu supirichuaru kea no tebiki* (Tokyo: Seikaisha, 2012); Ozawa Taketoshi, *Iryōsha no tame no jissen supirichuaru kea* (Tokyo: Nihon Igaku Shinpōsha, 2008); Okamoto Takuya, *Daremo oshiete kurenakatta supirichuaru kea* (Tokyo: Igakushoin, 2014).

studies of patients who experienced spiritual pain, and practical strategies for providing spiritual care.¹¹

All of these clinical studies constitute primary sources for this dissertation and will be examined in greater detail in Chapter Three. Unsurprisingly, they generally lack a reflexive concern for what spiritual care in hospices can tell us about the broader context of contemporary Japanese religion. Instead, they are rightfully concerned with how hospice staff might go about providing the best possible spiritual care to patients.

The second category of scholarship is written from an academic perspective, though, as we will see below, not necessarily one that is less normative than the first. Authors include a growing number of Japanese religious studies scholars who have examined the role of religion in medical settings to show how spiritual care is part of a newfound public interest in “spirituality” (*supirichuariti* スピリチュアルティ) in modern Japan. These studies attend to the historical reasons spirituality became a buzzword in healthcare settings, the medicalization of spiritual care, the discursive contestation over what constitutes spiritual care and why religious professionals are seeking to engage in spiritual care in the first place.¹²

One key figure in the academic study of spirituality in Japan is Shimazono Susumu 島薮進 (1948-). Shimazono is a prolific and distinguished scholar who taught for many years at the University of Tokyo before retiring in 2013 to become director of the Institute of Grief Care at Sophia University, which has become a hub for spiritual care training programs in Japan.

¹¹ Authors include Kubotera Toshiyuki, Waldemare Kippes, Itō Takaaki, Taniyama Yōzō, Murata Hisayuki, Ōshita Daien, Takagi Yoshiko. See also the special issues of *Kanwa kea* published in 2005, 2009, and 2012.

¹² For example, see Shimazono Susumu, *Supirichuariti no kōryū: Shinreisei bunka to sono shūhen*, (Tokyo: Iwanami Shoten, 2007); Ando Yasunori, “Seishin bunseki to supirichuariti,” in *Supirichuariti no shūkyōshi*, Tsuruoka Yoshio and Fukasawa Hidetaka eds. (Tokyo: Riton, 2010), 373-397; Kasai Kenta and Itai Masanari eds., *Kea to shite no shūkyō* (Tokyo: Akashi Shoten, 2013).

Shimazono was an important pioneer in the study of what have been called “new spirituality movements” (*shin reisei undo* 新靈性運動) in Japan. According to Shimazono, these new spirituality movements bear a marked similarity to what has been described as “new age” in the West, and include such themes such as alterations of mind and spirit, a search for the self, self-realization, self-transcendence, and self-liberation.¹³ Shimazono has argued that the advent of new spirituality movements can be traced back to the 1970s, and he distinguishes them from what he terms “historic religions, new religions, and new new religions.”¹⁴

In Shimazono’s religious typology, he classifies historical religions such as like Buddhism or Christianity, which are world renouncing and promise salvation in the afterlife, as salvation religions. New religions like Kurozumikyō, Tenrikyō or Sōka Gakkai that were founded in the nineteenth or early twentieth century are also classified as salvation religions but differ from historical religions in that they emphasize “this-worldly salvation” and preach improvement of a person’s immediate life in this world.¹⁵ The third category of “new new religions,” those founded in Japan’s postwar (1945-) period such as Kōfuku no Kagaku and the God Light Association (GLA), are not considered “salvation religions” because they tend to emphasize ideas such as “personal transformation” (*jiko hen’yō* 自己変容) or “healing” (*iyashi* 癒し).¹⁶ In contrast to these categories, Shimazono charts the rise of new spirituality movements, which share some similarities with new new religions but have less of a

¹³ Susumu Shimazono and Tim Graf, “The Rise of the New Spirituality,” in *Handbook of Contemporary Japanese Religions*, Inken Prohl and John Nelson eds. (Leiden: Brill, 2012), 460.

¹⁴ *Seishin shakai no yukue: Shūkyō, kindai, reisei*, (Tokyo: Akiyama Shoten, 2007), 2.

¹⁵ Shimazono, *Seishin shakai*, 5.

¹⁶ Shimazono, *Supirichuariti no kōryū*, 63.

soteriological or institutional emphasis, since spirituality movements supposedly promote spiritual growth on an individual basis or through very loose networks.¹⁷

Shimazono successfully locates new spirituality movements in Japan's socio-cultural and historical contexts. His typology of Japan's religious landscape also helps draw attention to commonalities and differences between traditional religious activities and new spirituality movements. As he notes, "spirituality" in Japan seems to be connected to global patterns of "spirituality" and yet also draws upon features of traditional Japanese religions. However, one difficulty with Shimazono's typology of religious movements is their tendency to reify the categories in question. Shimazono himself is aware of this danger and goes to great lengths to show how traditional forms of religious activity and spirituality movements inform and influence each other.¹⁸ Even so, in seeking to differentiate between historical religions and new spirituality movements and culture, he ultimately suggests that the discourse of spiritual care in hospice settings constitutes something different than that found in historic religions like Christianity or Buddhism.¹⁹ Yet the difficulty of this argument lies in the fact that it is mostly Christian and Buddhist groups who have spearheaded and continue to lead the spiritual care movement in Japan. Thus it remains to be seen how "spirituality" in hospice care might be examined apart from the Buddhist and Christian actors who are involved in promoting spiritual care.

Another key figure in the academic study of Japanese spirituality is Horie Norichika 堀江宗正 (1969-), a younger scholar of religion and spirituality at the University of Tokyo. Horie understands "spirituality," an English loan word, to be primarily a relabeling of religion in the

¹⁷ *From Salvation to Spirituality: Popular Religious Movements in Modern Japan* (Melbourne: Trans Pacific Press, 2004), 23.

¹⁸ Shimazono and Graf, "The Rise of the New Spirituality," 482.

¹⁹ Shimazono, *Supirichuariti no kōryū*, 282.

Japanese context. As he explains, “The *katakana* words for ‘spiritual/spirituality’ function as signs of security in a social climate that considers that religion is dangerous and should be excluded to maintain the social order. Thus, the use of the terms “spiritual/spirituality” enable people to hide and keep their intrinsic religiosity by positioning themselves closer to secularism.”²⁰ By arguing that “spirituality” is simply a different label or rebranding of religion, Horie rejects an essentialist view of spirituality. In other words, where Shimazono sees public interest in spirituality as a departure from traditional religious activities, Horie argues that the term “spirituality,” is actually just a floating signifier. Citing the popular backlash against religious groups in the wake of the Aum sarin gas attack on the Tokyo subway in 1995, Horie argues that, as religion became a pejorative label in Japan in the late 1990s, the term “spirituality” came to be used more frequently as a synonym. Horie also argues that many religious scholars, transpersonal psychologists, and spiritual care workers define “spirituality” in essentialist terms because they are personally invested in the concept; their arguments reflect subjective commitments to the notion of spirituality.

Horie’s view of spirituality also differs from Shimazono in that he does not see Japanese spirituality as part of a global pattern but distinct from it. For example, he argues that Western notions of “spiritual” and “spirituality” have stronger ties to traditional religion than the Japanese equivalents.²¹ The most direct translation of “spirituality” into Japanese is *reisei* (霊性). However, because the word *reisei* evokes notions of “spirits” or supernatural beings (*rei* 霊), most Japanese prefer to use the English loan word of “spirituality,” since it is free of associations

²⁰ Horie Norichika, “Spirituality and the Spiritual in Japan: Translation and Transformation,” *Journal of Alternative Spiritualities and New Age Studies* 5, (2009), accessed August 31, 2013, <http://www.asanas.org.uk/files/005/Horie.pdf>.

²¹ Presumably, this is because in English, the term “spiritual” is often used as a synonym for “religious.”

with ghosts, spirits, or organized religion. Thus when a person invokes a term like “spirituality” in the post-Aum context, this suggests that they are trying to distance themselves from organized religions.

Horie’s contributions to the study of spirituality in Japan help point out several things. First he highlights the importance of carefully distinguishing between Western and Japanese notions of “spirituality.” In other words, use of the English loan word “spirituality” does not mean that all its Western associations are preserved in Japan. Second, he shows how the term “spirituality” functions as a placeholder for religious subjectivity in post-Aum Japan. Third, he scrutinizes why the term has gained currency in academic circles, despite the fact that few ordinary Japanese employ the term in daily life.

Horie’s argument that spirituality is largely a euphemism for intrinsic religiosity provides an important corrective to essentialist understandings of spirituality. Yet, at the same time, it does not fully explain why spirituality and religion are so clearly distinguished by those who use these terms. For instance, many of the hospital chaplains cited by both Shimazono and Horie as important voices in popular discourse on spirituality make a point of distinguishing between providing “religious care” and “spiritual care” for hospice patients.²² In order to understand the significance of why these distinctions are made, it is necessary to examine more closely how these terms are utilized in practice.

²² Kubotera Toshiyuki, *Supirichuaru kea nyūmon* (Tokyo: Miwa Shoten, 2000), 58-59; Taniyama Yōzō, “Supirichuaru kea wa shūkyōteki kea to kotonatte iru,” *Lifence*, accessed July 7, 2013, <http://mag.gto.ac.jp/cat8/post-66.html#h4-2>.

The Approach of This Study

My contribution to the study of spiritual care in Japan departs from prior scholarship in several important ways. First, while clinical studies on spiritual care help delineate varying perspectives on idealized models of spiritual care, and academic studies of the discourse on spirituality demonstrate the larger religious and social context for spiritual care, they both lack attention to the actual lived practice of spiritual care in the hospice setting. What does a typical day look like for chaplains? What are some of the concrete ways in which they interact with patients? What practical principles guide their work? These are questions that have yet to receive concentrated attention. Partly, this is because very little ethnographic work has been done on Japanese hospice care.²³ One of the most important works in this regard is by Susan Orprett Long, whose study of end of life care in Japan remains one of the few sustained ethnographic treatments of this subject.²⁴ In her book, Long pays particular attention to the role played by cultural scripts in determining what is a “good death” for Japanese. However, while she does discuss spiritual care in passing, it is not the focus of her study. Most of her fieldwork was conducted in the mid 1990s, when hospice care in Japan was still finding its feet and spiritual care was largely unheard of.

²³ One exception is a 2007 unpublished dissertation by Arita Megumi, who conducted ethnographic fieldwork at a hospice in central Japan. Her study examined the way patients faced the end of life from the perspective of developmental psychology and showed through a series of conversations with patients that the crises that many Japanese face prior to death tend to be less personal and more relational, having to do with how they conceive their relations to family members or society. Arita Megumi, “Shōgai hattatsu shinrigaku’ kara toraeru shi: Makki gankanja to no taiwa kara,” (PhD diss., Kyoto University, 2007). On the need for more ethnographic studies of hospice care, see Matsuoka Hideaki, “Tāminaru kea ni okeru supirichuariti: Bunka jinruigaku kara no shiten,” *Kokusai keiei, bunka kenkyū* 12, no. 1 (November 2007): 73-85.

²⁴ Susan Orprett Long, *Final Days: Japanese Culture and Choice At the End of Life* (Honolulu: University of Hawai’i Press, 2005). See also her “Negotiating the “Good Death”: Japanese Ambivalence about New Ways to Die,” *Ethnology* 40 (2001): 271-89, and “Reflections on Becoming a Cucumber: Images of the Good Death in Japan and the United States,” *Journal of Japanese Studies* 29, no. 1 (2003): 33-68.

My approach also differs from prior studies that take the term “spiritual” for granted, or even celebrate it.²⁵ In addition to invoking a very ambiguous concept, the latent danger of this approach is that it often uncritically demarcates the “spiritual” from “religion” by portraying the former as individualized, interiorized, and non-dogmatic, and the latter as its opposite: institutionalized, exteriorized, and rigid. Such essentialized definitions not only reify these categories but also obscure the ways in which individual beliefs and practices are socially constituted. More perturbingly, these portrayals end up confusing scholarly classification with theological judgment.²⁶ Celebrations of rising public interest in “spirituality” as embodying a liberal individualistic alternatives to authoritarian religious beliefs and modern rationalism also occur in Western scholarship, where the interpretive categories of “self” and “freedom” oftentimes reproduce the very discourses on spirituality they seek to describe.²⁷ Even ostensibly academic studies of spiritual care can wind up celebrating spiritual care as emblematic of the potential for a post-modern, individualistic, ecumenical, and non-authoritarian form of religious social activism and religious subjectivity. For example, as Kerry Mitchell has pointed out, by the end of Leigh Schmidt’s excellent historical study of American spirituality, the subjects in his study emerge as “pillars of democratic freedom and a progressivism that could extend beyond

²⁵ I will discuss this in more detail in Chapter Three.

²⁶ Several scholars who have criticized this tendency include Horie, “Spirituality and the Spiritual”; Matthew Wood, “The Sociology of Spirituality: Reflections on a Problematic Endeavor,” in *The New Blackwell Companion to The Sociology of Religion*, ed. Bryan S. Turner (West Sussex, UK: Wiley-Blackwell 2010), 267-285; Craig Martin, *Capitalizing Religion: Ideology and the Opiate of the Bourgeoisie*, (London: Bloomsbury, 2014), 62-63; Jonathan R. Herman, “The Spiritual Illusion: Constructive Steps Towards Rectification and Redescription,” *Method and Theory in the Study of Religion* 26 (2014): 167.

²⁷ Kerry A. Mitchell, “The Politics of Spirituality: Liberalizing the Definition of Religion,” in *Secularism and Religion Making*, Markus Dressler and Arvind-Pal S. Mandair eds. (Oxford: Oxford University Press, 2011), 126.

America's borders."²⁸ By contrast, this dissertation will take a more cautious approach. My interest in the spiritual is not in describing it as a third space, neither religious nor secular, let alone of celebrating it. As a matter of fact, empirical evidence for a sustained "boom" in Japanese public interest in spirituality remains dubious.²⁹ Rather, while fully acknowledging that spiritual care can greatly benefit hospice patients, I will show how a closer look at its actual practice in Japan reveals how the term "spiritual" obscures the diverse concerns that patients articulate at the end of life and how hospice workers care for them.

Context and Key Terms

This section will discuss the cultural and religious contexts of spiritual care in Japan, along with some of the key terms in this dissertation. I will first provide some background on an ongoing scholarly debate about how far Japan can be considered as "secularized." I will also note important demographic changes in contemporary Japanese society and their impact on the hospice movement. After briefly describing institutions of hospice care in Japan and identifying the main actors who provide spiritual care in hospice settings, I will then discuss what the key terms "spiritual" and "care" mean to this dissertation.

Religion and Secularization in Japan

One of the live debates in the study of Japanese religion centers on the topic of secularization.³⁰ As stated above, judging by most indicators, institutionalized religion in Japan is on the decline. Yet despite statistical indicators of growing secularism, there has been

²⁸ Ibid., 133.

²⁹ Reader, "Secularisation R.I.P?" 30.

³⁰ Satoko Fujiwara, "Secularity and Post-Secularity in Japan: Japanese Scholars' Responses," *Journal of Religion in Japan* 5 (2016): 93-110.

reluctance amongst some scholars of Japanese religions to paint this broader picture.³¹ Instead, scholars like Shimazono Susumu and Kashio Naoki have focused their attention on alternative expressions of religious belief and practice as found in the emergence of new “spiritual” movements.³² From a cynical point of view, the growth of academic literature on “spirituality” in Japan could even be regarded as something of a gambit by academics to stave off the signs of secularization that threaten their academic livelihood. However, although statistical evidence of declining religiosity is important and might tend to support Horie’s view that the purveyors of academic discourse on spirituality may be overly invested in their topic, the application of secularization theory to Japan is no less problematic.

First, as Mark Mullins notes, it remains difficult to apply Western notions of secularization to Japan, since the two countries have undergone very different historical developments. For instance, in contrast to the trajectory of Western secularization in which religious decline goes hand in hand with modernization, State Shinto actually grew during Japan’s modernization before American occupiers forcefully removed it from Japan’s public sphere after the Second World War (1945-). Even after the war, hundreds of new religious movements emerged in Japan, right at the same time that the country was going through a second major period of modernization.³³

³¹ Reader, “Secularisation R.I.P.?” 23.

³² Shimazono, *Supirichuariti no kōryū*; Shimazono and Graf, “The Rise of the New Spirituality”; Kashio Naoki, *Supirichuariti kakumei: Gendai reisei bunka to hirakareta shūkyō no kanōsei* (Tokyo: Shunjusha, 2010).

³³ Moreover, it is noteworthy that Japanese politicians still feel compelled to visit Yasukuni Shrine and engage in rhetoric promoting a restoration of Shinto in the public sphere. This suggests a pressure on the Japanese state to reverse the legacy of American occupiers who purged Shinto from the public sphere. Mark Mullins, “Secularization, Deprivatization, and the Reappearance of ‘Public Religion’ in Japanese Society,” *Journal of Religion in Japan* 1, no.1 (2012): 63-68, 74.

Second, the drop in traditional indicators of religiosity in Japan, such as religious membership, participation in religious rites, or visits to temples or shrines, do not always correspond to secularization, since these traditional “indicators” do not always reflect the dynamic changes occurring in Japan’s religious landscape. As Jolyon Thomas has pointed out, comic books (*manga*) and animation (*anime*), which make up the bulk of Japanese publishing and film industry today, are important areas where religious themes are being produced and consumed in contemporary Japan. Thomas employs the neologism of “religious play” (*shukyō asobi* 宗教あそび) to address these gray areas of religion and entertainment which fall between the cracks of notions of religion as tied to systems of communal symbols, beliefs, and practices. Thomas also argues that the “spirituality” found present in such media can be safely classified as a subset of religion. As he notes, not only are spiritualities, like religion, usually based on perceptions of common membership in an audience or similar community, but the very fact that it is primarily scholars of religion who study spirituality also suggests its close resemblance to religious traditions.³⁴

Third, the religious versus secular binary can also be constrictive. In his study of the popularity of Christian wedding ceremonies in Japan, Jesse LeFebvre has argued that most Japanese define themselves as “not religious” (*mushūkyō* 無宗教) to signal their distance from religious behaviors that are considered “deviant, atypical, or extraordinary.” Instead, what most Japanese mean when they say they are “not religious,” is that they are not cognitively committed to any one particular religious tradition; nonetheless, they may still participate in religious activities with affective sincerity and often do so, not directly through their own actions, but

³⁴ Jolyon Baraka Thomas, *Drawing on Tradition: Manga, Anime, and Religion in Contemporary Japan* (Honolulu: University of Hawai‘i Press, 2012), 13.

vicariously, through the work of religious professionals who offer an eclectic range of religious services to them.³⁵ For example, LeFebvre shows how many “not religious” Japanese pray with sincerity at Christian wedding ceremonies. This explains how Japanese who claim to be “not religious” still express a range of religious dispositions that complicate the binary between religious and secular. In a similar vein, Isaac Gagne challenges the bifurcation of the religious and secular by showing how religious and ethical practices in contemporary Japan are not based on a distinct religious subjectivity, such as commitment to a particular religious community or doctrinal position, but are rather rooted in “malleable repertoires of vitalistic, ‘spirit-focused’ empowerment” and self-improving practices that take place across private and public contexts.³⁶

My dissertation will build on these studies that seek to move beyond assessing contemporary Japanese religiosity in terms of the binaries implied by theories of secularization. For instance, although outwardly, religion plays a very marginal role in the daily care of hospice patients, my personal interviews with Japanese chaplains reveal a more complicated picture. Chaplains readily admitted to me that explicitly religious forms of care such as prayer, reading scriptures, or providing soteriological advice, constitutes only a small part of their daily activities. Nonetheless, they also pointed out that their work cannot be done by just anyone, and that their religious identity remains integral to their work. Similarly, although hospice patients rarely raise religious questions about what lies beyond death, few patients do report that they find relief by “holding on to” something transcendent. Such tensions reveal how Japanese chaplains are caught in a complex web of conflicting expectations about what their role should be. These include

³⁵ Jesse LeFebvre, “Christian Wedding Ceremonies: ‘Nonreligiousness’ in Contemporary Japan,” *Japanese Journal of Religious Studies* 42, no. 2 (2015): 201.

³⁶ Isaac Gagne, “Private Religion and Public Morality: Understanding Cultural Secularism in Late Capitalist Japan” (PhD Diss., Yale University, 2003), 13.

expectations by doctors and nurses that they will not abuse their position in the medical ward to impose their religious views on patients; expectations by scholars of religion and the media that spiritual care represents an exciting story of how religious groups are initiating new ecumenical and psychotherapeutic roles for themselves in the public sphere; and expectations by religious professionals themselves who see spiritual care as an opportunity for social engagement with a Japanese public that increasingly identifies itself as “not religious.”

Why is Hospice Care Growing in Japan?

Japan is in the midst of a dramatic demographic crisis with profound implications for its society. As of September 2016, 27.3% of Japanese were aged sixty-five or older—the highest percentage in the world. By 2065, this number is expected to rise to a staggering 38%, meaning that more than one out of three Japanese will be sixty-five or older.³⁷ The two charts below dramatically capture this demographic shift. The progressive graying of Japan’s population will, and has already begun to, put extreme pressure on families who must care for their elders at the end of life.

³⁷ According to Japan’s National Institute of Population and Social Security Research, Japan’s total population is expected to decline by about forty million people, from its peak of 128 million in 2008 to approximately 88 million in 2065. Although the Japanese government has as a matter of urgency instituted various policies to encourage families to bear more children, these have only been marginally successful. Japan’s birth rate in 2015 stood at 1.45 births per woman. This represents a slight rise over the all-time low rate of 1.2 between 2003 and 2005. However, it remains below the replacement fertility rate of 2.1, which Japan maintained during the 1960s, and well below the postwar baby boomer rate of 4.5 in 1947. National Institute of Population and Social Security Research, “Nihon no shōrai suikei jinkō (Heisei 29nen suikei),” accessed May 11, 2017, http://www.ipss.go.jp/pp-zenkoku/j/zenkoku2017/pp29_gaiyou.pdf.

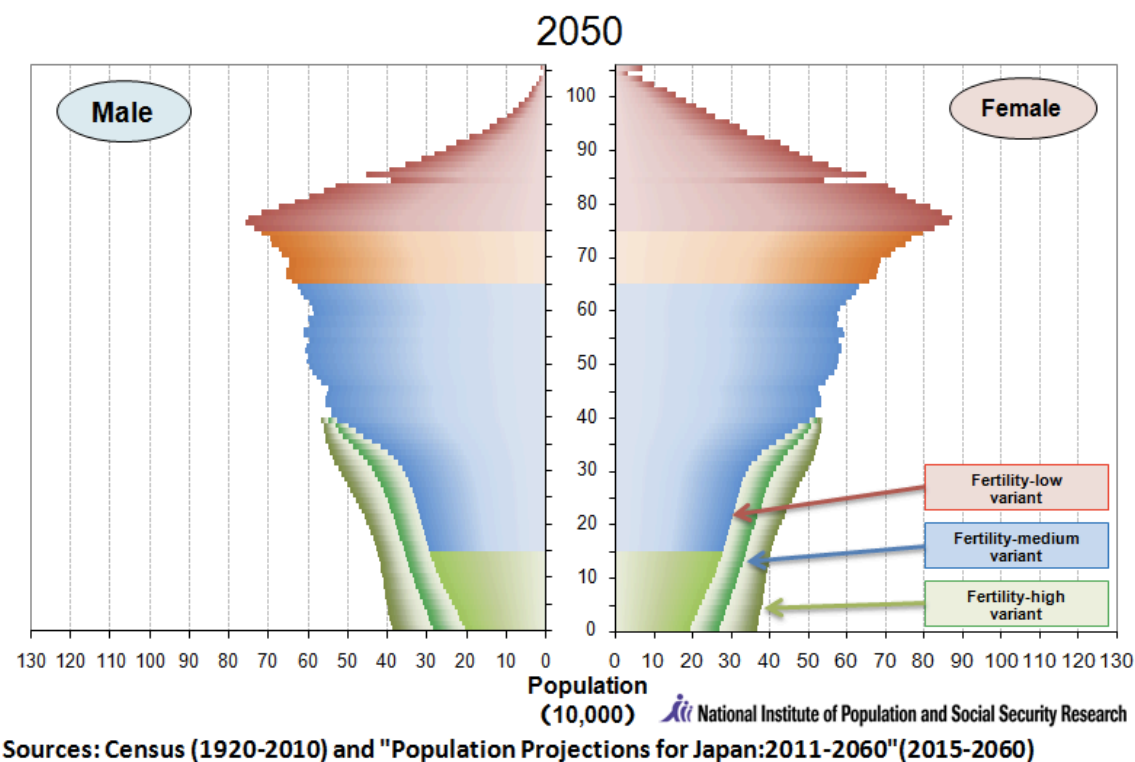
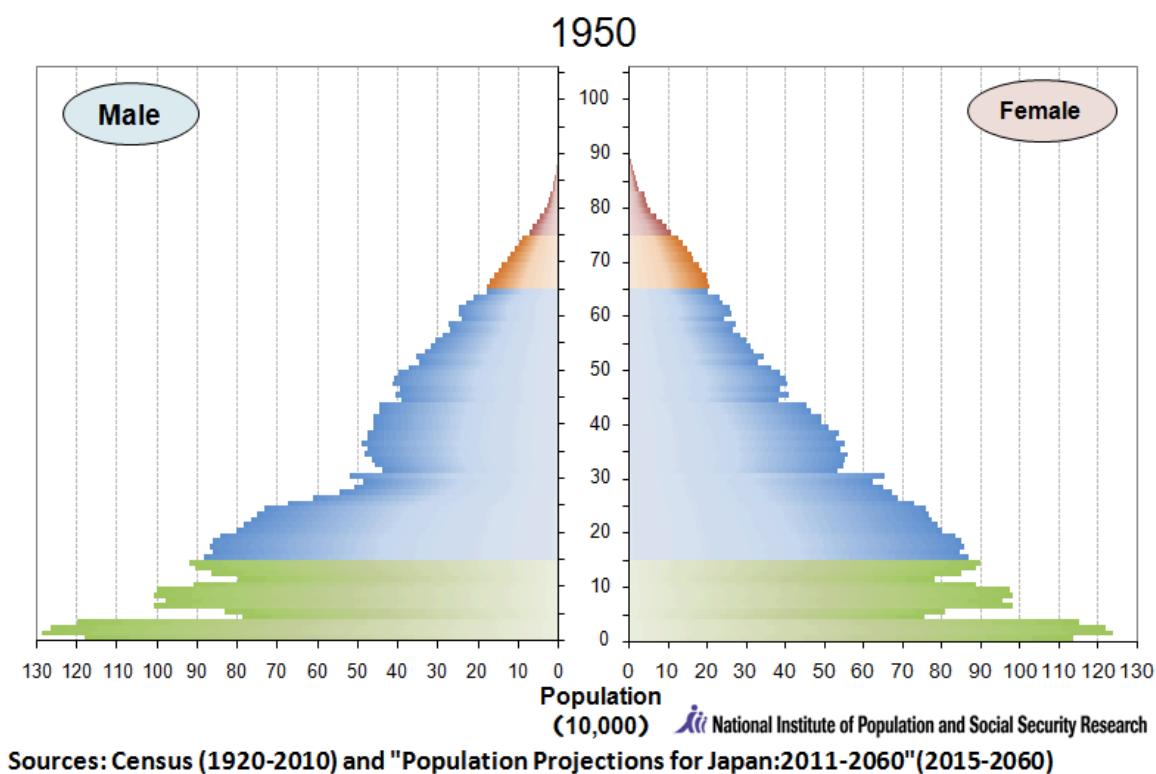


Figure 1. Demographic Shifts in Japan (1950-2060)

The growing need for hospice care is tied, not only to Japan's rapidly aging population, but also to important changes in the structure of Japanese households that have affected the ability of families to care for their elders. Over the last several generations, the relative number of nuclear families has risen in Japan, while the number of three generational households has declined. The number of single member households has also risen. These changes are often attributed to the rise of conjugal ideals that emphasize living apart from one's parents, as well as the space constraints of urban living. Thus far, however, these changes have not completely undermined the traditional Japanese stem family since many children will move back home to care for their parents in their hour of need.³⁸

However, the resilience of traditional family structures in Japan is being tested in new ways. Simply put, even if children are willing to move back home to care for their parents, without large-scale immigration or a change in Japan's historically low birth rate, there are just not enough children to care for their elders. In the past, daughters-in-law traditionally bore the responsibility of living with and caring for their husband's parents. However, the growing number of married women who remain in the workforce has makes this task increasingly difficult. Moreover, if the daughter-in-law is an only child, she is likely to be responsible for the care of her own parents as well. In rural areas, where depopulation is particularly acute, the

³⁸ Katō Akihiko has argued that half of newlyweds who were born in the 1920s chose to live with one or both of their parents compared to only 20% of newlyweds born in the 1960s. Yet, the number for both groups converged to 30% beyond the ten-year mark of marriage. This indicates that although Japan's postwar generation initially chose to live separately from their parents, such arrangements were often temporary. In many cases, the oldest son or daughter later returned to live with his or her parents for reasons related to household succession, property inheritance, and support of their elderly parents. Kato Akihiko, " 'Chokkei kazokusei kara fūfu kazokusei e wa hontō ka,'" in *Kōhōto hikaku ni yoru sengo Nihon no kazoku hendō no kenkyū*, Kumagai Sonoko and Ōkubo Takaji eds. (Tokyo: Hihon kazoku shakai gakkai zenkoku kazoku chōsa iinkai, 2005), 139-154; "The Japanese Family System: Change Continuity, and Regionality over the Twentieth Century," Max Planck Institute for Demographic Research (March 2013), accessed September 21, 2017, <http://www.demogr.mpg.de/papers/working/wp-2013-004.pdf>.

problem is compounded by a lack of job opportunities that would allow children to return home. This demographic crisis has no immediate solution in sight as Japan's birthrate remains stagnant and the possibility of large-scale immigration remains politically unpopular.³⁹ Coupled with Japan's life expectancy rates, among the highest in the world, the prospect that a growing percentage of the current population will live well into their eighties and nineties presents a genuine dilemma. Who is going to care for the elderly as they approach the end of life?

Where to Die?

For most Japanese, the default place to die is the hospital. This is particularly true for cancer patients. Currently, cancer accounts for nearly a third of all deaths in Japan and remains the leading cause of death among those aged forty to eighty-nine years. In 2015, 2.9% of Japanese cancer deaths occurred in a nursing home, 10.4% at home, 74.3% in a hospital or clinic, and 11.6% in a hospice. Although just over a tenth of cancer deaths currently take place in a hospice, this number is trending upward. For example, a decade prior, only 5.3% of cancer deaths occurred in a hospice while 88% of such deaths took place in a hospital.⁴⁰

There are many benefits to dying in a hospital. First of all, it is convenient. In fact, for those who live in rural areas with no hospice nearby, dying in a hospital might be the only option. More importantly, however, dying in a hospital ensures that patients can retain access to life extending treatments until the very end. For patients who wish to extend their life as long as

³⁹ Kōseirōdōshō, *Heisei 25nen (2013) jinkō dōtai tōkei (kakuteisū) no gaikyō* (September 11, 2014), 14, accessed December 18, 2014, http://www.mhlw.go.jp/toukei/saikin/hw/jinkou/kakutei13/dl/09_h5.pdf; Statistics Bureau, *Japan Statistical Yearbook 2015* (Ministry of Internal Affairs and Communications), 68, accessed December 18, 2014, <http://www.stat.go.jp/english/data/nenkan/pdf/yhyou02.pdf>.

⁴⁰ For a statistical overview of hospice care in Japan, see Igarashi Naoko and Miyashita Mitsunori, “Dētā de miru Nihon no kanwa kea no genjō,” in *Hosupisu kanwa kea hakusho 2017: Shōni kanwa kea no genjō to tenbō*, Shima Yasuo et al. eds. (Tokyo: Seikaisha, 2017), 78-107.

possible, having full access to a range of diagnostic and treatment services is no small blessing.

For instance, one patient I met had been battling cancer for more than a decade before finally entering a hospice. She had undergone every possible treatment and had visited countless specialists. She told me that some patients liked to complain about the side effects of multiple treatments, but she had a different perspective: “I say, if you don’t like it you can go home. Your cancer will just get worse.” Although this patient eventually embraced hospice care when she had run out of treatment options, it was clear that battling with cancer was important for her. Refusing to go gently into the night helped her cope with her suffering.

However, for most patients, dying in a hospital is far from ideal. One major drawback is the medicalizing of death. This problem is laid out clearly by Yamazaki Fumio in his 1990 bestseller, *Dying in a Japanese Hospital* (*Byōin de shinu to iu koto* 病院で死ぬということ), which was later made into a film. In this book Yamazaki shares the story of five patients who died horrible medicalized deaths, contrasted with five patients who died dignified, humane deaths, and argues that Japanese hospitals are too focused on treating the disease but ignore the person. Yamazaki describes an interaction between one patient and his doctor as follows: “The concern of the doctor in charge of him rapidly receded once it was seen that the treatment had little effect. When he came on his rounds, he didn’t look Kinoshita in the eyes. All he did was to encourage him in a loud voice. Then he hurried away. He was interested only in the cancer, not in Kinoshita as a person.”⁴¹ Yamazaki concludes by calling for more hospice care where patients are treated holistically, with fewer medical interventions, with fuller and more honest prognosis disclosure, and where spiritual care is made available to all patients.

⁴¹ Fumio Yamazaki, *Dying in a Japanese Hospital*, Yasuko Claremont trans. (Tokyo: The Japan Times, 1996), 51.

What Do Hospices Look Like?

While a history of hospice care in Japan will be given in the following chapter, it is useful here to consider a few background facts. The word hospice, stems from the Latin *hospe*, meaning “hospitality,” and originally referred to places of shelter provided by religious orders in medieval Europe to travelers and the sick.⁴² The first modern hospice, Saint Christopher’s Hospice, opened its doors in London in 1967 under the leadership of Dame Cicely Saunders (1918-2005), famed as the founder of the hospice movement. In Japan, the first official hospice ward opened in 1981, and many more were established after palliative care came under the aegis of Japan’s national health insurance in 1990. As of 2017, there are an estimated 394 palliative care wards (*kanwa kea byōtō* 緩和ケア病棟), or hospices (*hosupisu* ホスピス), in Japan.⁴³ On average, each hospice has about twenty beds, and in 2015 the average length of stay was just under thirty-three days and is trending downward.⁴⁴ Officially, hospice care is described in regulations by the Ministry of Health, Labor and Welfare as “palliative care” (*kanwa kea* 緩和ケア), and this term is used interchangeably with “hospice” (*hosupisu* ホスピス) in the media.⁴⁵ In this dissertation, I will primarily use the more general term “hospice.”

⁴² For an overview of the early history of hospice care see Cathy Siebold, *The Hospice Movement: Easing Death’s Pains* (New York: Twayne Publishers, 1992), 13-21. In Japanese, see Maruyama Seishin, “Shi no iryōka to taminaru kea,” in *Gendai iryo no shakaigaku: Nihon no genjō to kadai*, ed. Kuroda Kōichirō (Kyoto: Sekai shisōsha, 1995), 245-262.

⁴³ Hospice Palliative Care Japan Website, “Kanwa kea byōtō nyūin todoke juri shisetsusū, byōshōsū no nendo suii,” last modified November 15, 2017, accessed April 9, 2018, http://www.hpcj.org/what/pcu_sii.html

⁴⁴ In 2000, the average stay was almost forty-seven days.

⁴⁵ In Japan’s CiNii article database, the number of search hits for “palliative care” outnumber “hospice” 7143 to 2275. However, in the Asahi Newspaper database, the number of articles that mention “hospice” outnumber “palliative care” 4072 to 2529 (April 10, 2017). Hospice care is sometimes also referred to as “terminal care” (*tāminaru kea* ターミナルケア), but this is less popular due to its negative connotations.

There are several different types of hospices in Japan. First, there are hospices that exist as a ward within a larger hospital building (*innai byōtō* 院内病棟). These types of hospices are by far the most common and represent over 80% percent of Japanese hospices. Second, about 15% percent of hospices are located in a separate building on hospital grounds (*innai dokuritsu* 院内独立). These hospices have several advantages over those that are located inside the hospital. These include greater freedom to design the facility to make it feel more homelike, along with additional perks, such as enabling patients to smoke without falling afoul of hospital regulations. A third type of hospice, of which there is only a handful, exists completely independently from a hospital (*kanzen dokuritsu* 完全独立). Other forms of hospice care include palliative care teams (*kanwa kea chīmu* 緩和ケアチーム) that are assembled in a hospital to treat cancer patients who are scattered across different wards. In 2014, approximately 13% of Japan's 7,426 hospitals had such teams in place to help treat terminally ill patients. Finally, home hospice (*zaitaku kanwa kea* 在宅緩和ケア) is provided by a range of small clinics and home-visit nursing stations that help care for Japanese cancer patients dying at home.⁴⁶

This study will focus on the first three types of hospices, where patients spend the end of their life in designated hospice wards. Although the flexibility that palliative care teams and especially home hospice provide for Japan's overcrowded hospitals is growing in importance, hospice wards where terminally ill patients are physically grouped in a designated hospital wing or building continue to be the norm in Japanese hospice care. This study will also refer to some

⁴⁶ In 2014, for example, there were over fourteen thousand cases recorded by home medical support clinics (*ryōyōshien shinryōjo* 療養支援診療所) and over six thousand cases by twenty-four hour home-visit nursing stations (*hōmon kango sutēshon* 訪問看護ステーション). Igarashi and Miyashita, "Dētā de miru."

hospices as “Buddhist,” “Protestant,” or “Catholic.” These are hospices that were founded by religious groups that continue to uphold the religious spirit of their respective denominations in their mission statement and in the provision of religious services, materials, and spaces to patients.

What Do I Mean by “Spiritual”?

The word “spirit” and its cognates are derived from the Latin *spiritus*, which was used in the fifth century to translate the Pauline theological concept of *pneuma* or “breath.” In Pauline theology, the “spiritual” (Gk. *pneumatikos* or Lt. *spiritualis*) is contrasted with the “flesh” (Gk. *sarkikos* or Lt. *carnalis*). Initially, a spiritual person referred to someone who walked according to the “spirit of God” instead of pursuing his or her own fleshly desires.⁴⁷ In the centuries that followed, the word took on a number of new associations, referring, for example, to contrast with the corporal world, to ecclesiastical persons and property, or to religious devotion. In the United States, the “spiritual” was further imbued with new meaning during the late nineteenth century when liberal and progressive Protestants began exploring beyond the boundaries of their inherited religious traditions to seek out more mystical, eclectic, and cosmopolitan varieties of religious practice.⁴⁸

In Japan, the word “spiritual” (*supirichuaru* スピリチュアル) is an English loan word, rendered in the *katakana* script to designate its foreign origins. It is therefore impossible to discuss the spiritual in Japan without acknowledging its recent and foreign provenance. A fuller genealogy of the term “spirituality” in Japan will be examined in Chapter Three. Here, I simply

⁴⁷ Walter Principe, “Toward Defining Spirituality,” *Studies in Religion* 12, no. 2 (1983): 127-141.

⁴⁸ Leigh Eric Schmidt, *Restless Souls: The Making of American Spirituality* (New York: HarperSanFrancisco, 2005).

make clear the complicated etymology of the word “spiritual” and emphasize that this study will not be concerned with generating a new definition of “spiritual” or “spirituality.” As indicated earlier in this chapter, my interest in the spiritual is not in describing it as a third space, neither religious nor secular, but rather how it is used by different actors in different contexts for different purposes. This study will suggest that the use of the term “spiritual” in Japanese hospices primarily functions as a negotiable boundary. That is to say, it helps sanction or prohibit the acceptable parameters of religious care for patients. I thus build on the work of other scholars who point out that spirituality is not merely a flawed scholarly category but scarcely an objective category at all. Rather, I seek to emphasize its importance as a component of contemporary religious discourse.⁴⁹

Viewing spirituality as primarily a discursive term is also an effective starting point for querying attempts to establish fixed definitions of what spiritual care really means in the hospice context. By taking a step back and observing how the term “spirituality” is being used variously in different contexts, we can see more clearly the competing interests that lie behind attempts to care for a patient’s “spirituality.” Chaplains, medical workers, and academics all have a stake in referring to spirituality as a concrete dimension of personhood that becomes the specific locus of “spiritual pain.” Viewing spirituality discursively also frees us to examine its entanglements with history and social life. For example, in her ethnographic study of spirituality in the United States, Courtney Bender seeks to understand how spiritual practitioners themselves invoke the language of spirituality. In doing so, her study moves beyond the search for static definitions to show how spirituality lies *in situ*, “entangled in social life, in history and in our academic and nonacademic

⁴⁹ Herman, “Spiritual Illusion.”

imaginations.”⁵⁰ Following Bender, I have tried to avoid presupposing or superimposing my own definition of spirituality or spiritual care. Instead, I seek to attend to the manner in which the hospice functions as a space where different stakeholders negotiate the range of meanings that orbit around the concept of “spirituality.” Ironically, this approach parallels the ethos of hospice care itself, which calls attention to the “whole person.” That is to say, instead of isolating spirituality in hospice settings as a discrete category of analysis, I hope to examine it holistically.

Who Cares?

In addition to questioning the “spiritual” as a concept, this dissertation will also examine the notion of “care” with special attention to the persons involved in providing it. In every clinical encounter there are care-givers and care receivers: doctors in solid white coats with stethoscopes slung around healthy necks greet and treat patients in flimsy gowns who extend their frail wrists encircled by unrippable ID bands. The word “care” used as a noun implies the act of providing something that can be called care. When I enroll my daughter in a child care program, hopefully, those responsible will feed her, play with her, and put her down for a nap. If my employers say that they provide health care, I expect a range of medical services to be at my disposal. However, this act of doing something to provide care is in a sense also at odds with the philosophy of spiritual care. Spiritual care is often spoken of by hospice workers in the abstract as not “doing” but “being.”⁵¹ In spiritual care you are not supposed *do* something for the patient but *be* there for the patient. Chaplains are expected to exempt themselves from the panopticon of medical supervision and simply sit beside the patient. However, as this dissertation will show,

⁵⁰ Courtney Bender, *The New Metaphysicals: Spirituality and the American Religious Imagination* (Chicago: The University of Chicago Press, 2010), 5.

⁵¹ Winnifred Fallers Sullivan illustrates this sentiment in the title of her book on chaplaincy, *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014).

chaplains, and even doctors and nurses who are committed to spiritual care, all *do* a lot of things that they describe as integral to the practice of spiritual care.

The primary givers of spiritual care are chaplains. However, all members of the hospice team in Japan are expected to practice spiritual care. In cases where there is no chaplain on the medical team or when the chaplain is only intermittently available, nurses are often on the front lines of the practice of spiritual care. The first thing to note about the duties of Japanese chaplains is that their work in the hospice may only represent a small portion of their daily responsibilities. Since the majority of Japanese hospice wards are part of a larger hospital, chaplains typically visit patients in all the hospital wards. Visits to the hospice may range from every day to just a few times a week, depending on the size of the hospital and the number of chaplains available. Some chaplains may also only work part time. For example, at one hospice, the Lutheran pastor visited just twice a month while at another hospice a Catholic chaplain visited hospice patients once a week while also working as an adjunct professor at a nearby university. At yet another hospice in Tokyo, a local Christian pastor and two Buddhist priests were on call to serve as chaplains only when necessary. However, in hospices with a religious affiliation, a chaplain typically works full time.

The exact number of hospital chaplains in Japan is hard to ascertain. According to a 2012 report published by the Japan Hospice Palliative Care Foundation, there were an estimated 176 chaplains working or volunteering at 68 different palliative care wards around Japan.⁵² However, another study estimated in the same year that there were only 60 chaplains at 37 hospice

⁵² Murase Masaaki et al., “Kanwa kea byōtō ni okeru shūkyōka no katsudō no genjō nit suite no shitsuteki kenkyū,” 2012, *Japan Hospice Palliative Care Foundation Website*, accessed April 10, 2018, https://www.hospat.org/assets/templates/hospat/pdf/report_2012/2012-c1.pdf.

institutions.⁵³ According to the Hospice Palliative Care Japan Website, in 2017, at least 58 of their 331 member institutions provided some sort of spiritual care to patients or their families through religious workers or volunteers.⁵⁴ Based on these numbers and my own fieldwork, I estimate that in 2017, there were approximately one hundred active hospital chaplains in Japan.

Research Methodology

Many years ago, when I was still working as a chaplain, I helped organize my hospital's annual "Whole Person Healing Study Retreat." This retreat was dedicated to reaffirming the hospital's motto of "Whole Person Healing" (*zenjin iryō* 全人医療), which was originally established by the Christian missionaries who founded the hospital with the aim of serving patients as a total unity of body (*karada* 身体), mind or heart (*kokoro* 心), and spirit (*tamashii* 魂). On the final day of the retreat, a panel session was devoted to discussing how one could care for the "spirit" of patients. "What exactly is a person's spirit?" somebody asked. After some discussion and plenty of confusion, one of the panelists looked to the back of the room where I was manning the video recorder and asked: "Tim-san, how would you describe a person's spirit?" Caught by surprise, I offered a clumsy and vague definition off the top of my head. As I now reflect on this moment, it is interesting to consider how I, the only foreigner in the room, was singled out as a "Western" authority to explain the Christian assumptions that formed the foundation for the hospital's cherished motto. In that moment, I was playing a small part in contributing to a global conversation about the nature of spirituality.

⁵³ Fujiyama Midori, " 'Rinshō shūkyōshi' no kanōsei o shakai no nīzu kara saguru: 'Rinshō shūkyōshi' o meguru kōsatsu/zenpen," 2012, Center for Information on Religion Website, accessed July 10, 2015, <http://www.circam.jp/reports/02/detail/id=3177>.

⁵⁴ "Kanwa kea byōto nyūin todokede-jurishisetsu ichiran," accessed May 8, 2017, http://www.hpcj.org/what/pcu_list.pdf.

The methodological challenges of this dissertation topic are in many ways akin to that experience in that while I am ostensibly attempting to record a fascinating discussion, I am also contributing to it. Although I suggested earlier that this study will distinguish itself from some of the normative approaches to spiritual care taken by Japanese hospice workers and scholars, an honest ethnographer knows that complete detachment is a chimera. Nevertheless, while I do not intend to (and cannot) erase my own role in helping shape the way spiritual care is both understood and practiced, my ultimate hope is to reflect on the big picture: what the history, discourse on, and practice of spiritual care can tell us about the role of religion in medicine and more broadly about the relationship between religion and Japanese society today.⁵⁵

In terms of the scope of my fieldwork, I have utilized a multi-sited approach. One of the primary drawbacks of this approach is the lack of depth to be gained by immersion in a single site for a long period of time. It also complicates my findings, since I must account for differences across multiple localities. However, conducting research across multiple sites also adds a rich layer of nuance and complexity occasioned by both local variation and the constant renegotiation of the ethnographer's role.⁵⁶ Most of my fieldwork took place during three summer visits in 2012, 2013, and 2017 and fourteen months of extended fieldwork between 2014 and 2015. During that time, I visited twelve hospices in Japan as well as three in Taiwan (not addressed in this study). I also conducted a concentrated two weeks of participant observation at a Catholic hospice, two weeks at a Protestant hospice, and two weeks at a Buddhist hospice. In addition to participant observation, I also conducted separate interviews with twenty chaplains,

⁵⁵ My role as a researcher is especially complicated since I previously worked as a hospital chaplain. However, while this certainly colors my view of spiritual care, this background was also serendipitous since it opened doors for access to hospice patients in order to conduct this research.

⁵⁶ George E. Marcus, *Ethnography Through Thick and Thin* (Princeton, NJ: Princeton University Press, 1998), 84.

eleven doctors, twenty-five nurses, and nine hospice patients in Japan as well as with several doctors, nurses, and chaplains in the United States and Taiwan.

Chapter Summaries

In Chapter Two, I begin by locating spiritual care within a longer historical narrative of the roles of Japanese religious groups in modern medical welfare activities. By outlining the historical background of hospice care, I show how discourse on the “degeneration” of Buddhism has been utilized as an engine to spur Buddhist engagement in modern medicine as a way of demonstrating its modern relevance, and how Christian medical missions paved the way for their pioneering role in the Japanese hospice movement by setting in motion a series of efforts by religious groups to show they could play a “healthy” role in Japanese society.

In Chapter Three, I examine theoretical discourse on “spirituality” and “spiritual pain.” In particular, I show how the concept of spirituality in the Japanese hospice has become reified and medicalized into a distinct dimension of being, alongside the physical and psychosocial dimensions of personhood, as we see in the World Health Organization’s definition of palliative care. I suggest that this insistence on a distinct, universal “spiritual dimension” has at times ironically undermined one of the central tenets of hospice care, which is to treat patients as whole persons. This chapter also shows how the search for “spirituality” is part of a global conversation in which Western and Japanese understandings of spirituality are being transposed and re-appropriated across cultural boundaries.

Chapter Four examines the actual practice of spiritual care in the Japanese hospice. Based primarily on my ethnographic fieldwork, I pay attention to how spiritual care is conducted by doctors, nurses, and especially chaplains. Through my fieldwork and interviews with hospice

workers, I demonstrate how spiritual care in Japan often goes beyond helping patients vocalize “spiritual pain” or addressing their anxieties directly through counseling, religious support, or being a sympathetic presence. Rather, much of spiritual care is also conducted in the margins of daily care, for example, through special hospice events or even in the course of prosaic activities. This diffuse approach elicits less resistance by Japanese patients and staff than do Western notions of end-of-life counseling or religious care.

In Chapter Five I focus on the topic of spiritual pain and the types of concerns that patients voice at the end of life. By collating interviews with hospice patients and chaplains, I examine several prominent themes about the kinds of anxieties terminal patients face at the end of life and where they turn for support. I then try to show how the anxieties Japanese hospice patients voice often calls into serious question the existence of a distinct category of “spiritual pain,” even while, in some cases, supporting it. As I demonstrate, many Japanese patients are unlikely to openly express their anxieties in religious or existential terms. However, chaplains also suggest that spiritual pain can also be latent, repressed, or sometimes just poorly articulated by Japanese patients. This suggests how, on one hand, discourses of spiritual pain and care can serve the needs of religious professionals and medical workers at least as much as the needs of patients. On the other hand, chaplains believe that spiritual pain is manifested in subtle ways that elide clinical diagnoses.

In the Conclusion I provide some final thoughts and discuss some larger themes that run through the dissertation. I also briefly reflect on the limits and potential of ethnography for research on death and dying. Finally, the appendices provide a list of religious hospices and spiritual care training programs in Japan.

Chapter Two

Healthy Religion:

Medical Welfare and the Birth of Hospice Care in Japan

My disciples, if you see someone who is ill, you should always make offerings to them, no differently than you would for the Buddha. Among the eight fields of merit, that of caring for the ill is foremost.

-The Brahmā's Net Sutra¹

One muggy summer afternoon in 2015, I was walking in Kyoto when I happened to come across a bookstore offering a large sale. As I perused some of the books set out on the sidewalk, a book caught my eye. It was titled: “The Reason a Zen Priest Aims to be a Doctor” and the author was Tsushimoto Sōkun 対本宗訓, a former Rinzai abbot who had resigned from his temple to enter medical school. As I skimmed through the pages, I lighted upon the following passage.

What on earth is it that parishioners expect of us priests? For the sake of the argument let's say that they only expect us to conduct funerals and memorial services. This would be truly sad. As Zen priests trained in fundamental Buddhist practices, what is it we can do to contribute to society? Is this not something that priests must individually consider as a theme in their activities? For example, problems in education, social welfare, and volunteer activities are all areas in which we can expect religionists (*shūkyōsha* 宗教者) to play a role.²

The view that modern Japanese Buddhist priests only interact with their parishioners in the context of funerary and memorial rites is a stereotype that is hard to shake. In fact, it has dominated public discussion on Japanese Buddhism for well over a century.³ One way modern

¹ A. Charles Muller and Kenneth K. Tanaka trans., *The Brahmā's Net Sutra: (Taishō Volume 24, Number 1484)* (Moraga, California: BDK America, Inc., 2017), 51, accessed April 11, 2018, <http://www.bdkamerica.org/book/brama%CC%84%E2%80%99s-net-sutra>.

² Tsushimoto Sōkun, *Zensō ga ishi o mezasu riyū* (Tokyo: Shunjusha, 2001), 120.

³ Stephen G. Covell, *Japanese Temple Buddhism: Worldliness in a Religion of Renunciation* (Honolulu: University of Hawai'i Press, 2005), 14-18; Mark Rowe, *Bonds of the Dead: Temples, Burial, and the Transformation of Contemporary Japanese Buddhism* (Chicago: University of Chicago Press, 2011),

Japanese Buddhists have sought to combat this stereotype and emphasize their value to society is by engaging in social welfare activities. For example, Inoue Enryō 井上円了 (1858-1919), Japan's most prominent Buddhist thinker and reformist during the Meiji period (1868-1912), spared no words in roundly critiquing the lack of Buddhist engagement in charitable works (*jizen jigyo* 慈善事業). In 1898 he wrote:

In each of the Buddhist sects, although perhaps inadequate, the encouragement of learning and spreading of teaching is being done to some extent, but in regard to reaching the first level of charity (*jizen no ichidan* 慈善の一段), we can say that we have not even begun to undertake this. Although Buddhism originally had charity at its basis (*moto* 本), and it has been understood that the Buddha mind (*busshin* 佛心) is to have great compassion (*daijihi* 大慈悲), though compassionate, in fact, the lack of charitable works is something I find truly hard to comprehend.

Inoue then goes on to compare Buddhism with Christianity.

The reason why Christianity is valued today in the West is because it promotes charity for the benefit of others. Consequently, if Christianity coexists [in Japan] with Buddhism in the future, and becomes officially recognized like Buddhism, Buddhism must compete in conducting charitable work. Therefore, today it is imperative [for Buddhists] to make these preparations.⁴

In this passage Inoue links the success of Christianity in the West to its charitable work for the benefit of others (*ritateki jizenjigyo* 利他的慈善事業). Inoue also critiques Japanese Buddhists for only conducting charitable work that had some self-interest involved (*jiriteki jizenjigyo* 自利的慈善事業) and warns that Buddhist groups may fall behind their Christian rivals in Japan. Not all Buddhists were as explicit as Inoue in using Christian social work as a foil for furthering a vision of Buddhist social welfare, but this passage shows the palpable sentiment amongst Buddhist reformers in the Meiji period that Buddhism had “degenerated” from its lofty teachings.

17-43. John K. Nelson, *Experimental Buddhism: Innovation and Activism in Contemporary Japan* (Honolulu: University of Hawai'i Press, 2013), 45-48.

⁴ Inoue Enryō, *Sōhei kairyōron* (Tokyo: Morie Shoten, 1898), 58, 61-62.

According to this now well worn narrative, Buddhism had become complacent under the Tokugawa government's temple registration rules that provided a stable parishioner base during the Edo period (1603-1868), retreated from charitable activities, and ossified into a religion solely dedicated to funerary and memorial rites.⁵ In order for Buddhists to demonstrate their worth to modern society, they needed to expand their expertise from care for the already dead to those who were still living in order to show they could play a "healthy" role in Japanese society.

The call by nineteenth-century religious figures like Inoue on the importance of Buddhists to engage in social welfare and charitable activities to display their relevance to modern society closely resembles the call by Buddhists today who advocate in a similar manner for greater involvement in activities like spiritual care. This chapter seeks to locate the practice of spiritual care in Japanese hospices within a broader historical narrative of Japanese religious engagement in medicine during the long twentieth century.⁶ Although the Japanese hospice movement and attention to spiritual care did not begin in earnest until the 1990s, a closer look at the first half of the century reveals a flurry of activity by religious groups in the fields of medical welfare that helped lay the groundwork for religious groups to play a prominent role in the hospice movement. For example, in the late nineteenth and early twentieth century, Buddhist and Christian groups in Japan were active in building hospitals and medical dispensaries, often

⁵ Tsuji Zennosuke, *Nihon bukk'yōshi no kenkyū* (Tokyo: Kinkōdō, 1931); Tamamuro Taijō, *Sōshiki Bukkyō* (Tokyo: Daihō Rinkaku, 1963). For a close study of this historiographical discourse, see Orion Klautau, "Against the Ghosts of Recent Past: Meiji Scholarship and the Discourse on Edo-Period Buddhist Decadence," *Japanese Journal of Religious Studies* 35, no. 2 (2008): 263-303.

⁶ I will not, however, focus on the role Japanese religion plays in psychoanalytic fields like Morita therapy, which has its own rich history. Instead, I will focus on institutionalized forms of medical welfare such as religiously affiliated hospitals that showcase the more "public" contributions of religious groups in medicine. For a thorough study of Japanese religion and modern psychotherapy, see Christopher Harding, Fumiaki Iwata, and Shin'ichi Yoshinaga eds., *Religion and Psychotherapy in Modern Japan* (Oxon: Routledge, 2015).

legitimizing their work by focusing on medical charity (*jizen* 慈善) as both a tenet of religious practice and a symbol of modernization.⁷

These types of activities are connected to the contemporary hospice movement in two ways. First, as the first section of this chapter will show, Japanese Buddhists frequently mobilize the discourse of Buddhist decline, along with historical precedents of Buddhist engagement in medical welfare and care for the dying in pre-modern Japan to promote the Buddhist hospice or Vihāra movement. Second, spiritual care is also entangled in the history of medical welfare by way of the establishment of religious hospitals that later became key sites for purveying the philosophy of hospice and spiritual care in Japan. For example, four of the first five hospices in Japan were founded at religious hospitals. Accordingly, the second section of this chapter will survey the contributions of Christian and Buddhist medical missions that began in the Meiji period up to the immediate postwar period (ca. 1945-1960) to show how these efforts set the stage for religious involvement in hospice care. In particular, it will show how Christian groups came to play a disproportionate role in the establishment of religious hospitals that later became influential centers for the practice of spiritual care. The third and final section will then turn to examine the origins of the hospice movement itself in the 1970s and 80s at several Christian hospitals, and the development of the Vihāra Movement shortly thereafter. It will also show how two key historical events in 1995—the Hanshin earthquake and the sarin gas attack by the religious group Aum Shinrikyō—helped clear the way for the spread of spiritual care in clinical practice more broadly in the twenty-first century.

⁷ Endō Kōichi, “Christian Social Welfare and the Modernization of Japan,” in *Handbook of Christianity in Japan*, ed. Mark R. Mullins (Leiden: Brill, 2003), 343-357.

Ultimately, this chapter will seek to place spiritual care in Japan—in discourse and on the ground—within its historical context. It will address such questions as: what role did Japanese religious groups play in medicine before the advent of spiritual care? Why are there so many Christian hospitals in Japan? How did religious groups become involved in hospice care in the first place? By filling in the historical background of hospice care in Japan, it will show how the narrative of Buddhist decline has remained an engine for Buddhist engagement in modern medicine and how Christian medical missions paved the way for Christianity’s pioneering role in the Japanese hospice movement. These activities helped set in motion a series of efforts by religious groups more broadly to show they could play a “healthy” role in Japanese society. This longer view of Japanese modern religious engagement in medicine thus also serves to problematize scholarship that depicts spiritual care and socially engaged Buddhism as only recent phenomena.⁸

Mobilizing History: Imagining a “Golden Era” of Buddhist Medical Welfare

Since there was a strong view amongst early twentieth century Buddhist scholars, and to a certain extent even today, that Japanese Buddhism had “degenerated” during the early modern period, Buddhist scholars often look further back in history for the “golden era” of religious engagement in medical welfare. Scholars such as Tsuji Zennosuke, Asano Kenshin, Moriya Shigeru, Ikeda Masatoshi, Yoshida Kyūichi, Hasegawa Masatoshi, Tamiya Masashi, and Miyagi

⁸ For example, John Nelson’s work on “experimental Buddhism” acknowledges the binary that the term “engaged Buddhism” provokes (what would unengaged Buddhism look like?) but nevertheless suggests that up until recently Buddhists were not “engaged” or “experimental” enough. For instance, he cautions that Japanese temple Buddhism is currently “at risk of becoming road kill on the freeway leading to a more globalized world.” Nelson, *Experimental Buddhism*, 19. For a new read on what socially engaged Buddhism represents, see Jessica L. Main and Rongdao Lai, “Introduction: Reformulating ‘Socially Engaged Buddhism’ as an Analytical Category,” *The Eastern Buddhist* 44, no. 2 (2013): 1-34.

Yōichirō have carefully documented charitable works by premodern Buddhists, often glossing them as early examples of social work. For example, Prince Shōtoku 聖徳 (574-622) is often touted as the progenitor of Buddhist social and medical welfare. In addition to helping introduce Buddhism to Japan, Prince Shōtoku is credited with the construction of Shitenōji, Japan's oldest temple, which included a dispensary (*seyakuin* 施薬院), hospital (*ryōbyōin* 療病院), and home for the needy (*hidenin* 悲田院) on its premises.⁹ Scholars also invoke figures like Empress Kōmyō 光明 (701-760) who helped construct a dispensary at the temple Kōfukuji in 730, or the peripatetic priest Gyōki 行基 (668-749), who helped construct shelters (*fuseya* 布施屋) for the elderly, travelers, the poor and the sick.¹⁰

Many of these historiographical discourses on religion and social welfare in Japan are embedded in a vision of reforming Buddhism to emphasize its contributions to contemporary society. For example, Tsuji Zennosuke 辻井善之助 (1877-1955), a professor at Tokyo Imperial University and Japan's preeminent prewar Buddhist historian, is known as one of the primary voices in the discourse of Buddhist “degeneration.” As part of his effort to show just how far Buddhism had fallen, in 1932, he published a thick volume titled *Historical Records of Charity and Relief* (*Jizen kyūsai shiryō* 慈善救済資料) which began as a project to collect historical

⁹ Tanaka Takashi, “Shitennōji goshuin engi no seiritsu o ronjite honpō shakai jigyō shisetsu no sōshi ni oyobu: Shōtoku Taishi to Shitennōji shikoin,” in *Bukkyō to fukushi*, Tamiya Masashi, Hasegawa Masatoshi, and Miyagi Yōichirō eds. (Tokyo: Keisuishsha, 1994), 153-172.

¹⁰ Moriya Shigeru, *Bukkyō shakai jigyō no kenkyū* (Kyoto: Hōzōkan, 1971), 189-198. Other figures often cited as examples of premodern Buddhist engagement with medical welfare include Chōgen (1121-1206) who built temple baths that were open to the poor and sick, while Ninshō (1217-1303) is said to have dedicated much of his life to the construction of hospitals, dispensaries, and sanitariums for lepers. Moriya, *Bukkyō shakai jigyō*, 239-261, 290-299. See also Asano Kenshin, *Nihon bukkyō shakai jigyō-shi* (Tokyo: Bonjinsha, 1934).

documents for display at a certain charity hospital in 1919.¹¹ Beginning with the earliest records of Japanese history and continuing up until the Meiji Restoration, Tsuji's book is a chronological anthology of records of charitable works, often by Buddhists, in Japanese history. Likewise, in 1934, Asano Kenshin 浅野研眞 (1898-1939) published a similar volume titled: *The History of Buddhist Social Work in Japan* (*Nihon bukk'yō shakai jig'yō-shi* 日本仏教社会事業史) that highlighted the social work undertaken by past Buddhists. Asano writes in his preface to the book:

Buddhism holds, over the past twenty-five centuries, a record of prior achievements in social relief. Surely today, and surely especially after the Meiji restoration, it might be thought that the field of modern social work was recently begun by Christians, but this is certainly not the case. This is because already from of old, in our Japan, Buddhists hands have been involved in and directed a wide range of various types of social work.¹²

Here Asano, like Inoue before him, promoted a vision of revitalizing and reforming Buddhism by citing past examples of Buddhist engagement in types of social work that were often credited solely to modern Christians. The book sought to emphasize Buddhism's own long tradition of social work activities.¹³ A growing Buddhist interest in playing a public leadership role in social welfare during the early twentieth century is most vividly seen in the monthly Buddhist journal *Kyūsai* 救済 or "Relief" which was published between 1911 and 1919 by the Ōtani Sect Charity Association which was part of the large Jōdo Shinshu school. This journal featured numerous articles on past examples of Buddhist social work as well as news reports about recent social welfare activities in Japan. As the first issue of this journal explained, underlying the formation of the Association and the journal was a strong consciousness of charitable works as

¹¹ Tsujii does not name the hospital.

¹² Asano, *Nihon bukk'yō shakai jig'yō-shi*, 3.

¹³ For more on Asano's views on Buddhist social work, see also Murota Yasuo, *Jinbutsu de yomu shakai fukushi no shisō to riron* (Kyoto: Minerva Shobō, 2010), 142-148.

“one of the pressing issues of the time,” and one in which many were “waiting on the strength of religionists” to do something. Moreover, the Ōtani sect felt especially obligated to act as “other religions draw on their own unique convictions to follow this path and are competing in their contributions.”¹⁴

Invoking past examples of Buddhist charity and social work as well as referencing the contemporary work Christians were already doing helped inform the call by reform-minded Buddhist priests for greater social engagement. In other words, Inoue Enryō’s perception that Buddhism had become “corrupt,” abandoning its pre-modern ideals that placed “charity at its center,” served a double purpose. Medieval precedents of social welfare activities provided evidence of a long history of Buddhist involvement in such activities and legitimized Buddhist expertise in fields like medical care. At the same time, such precedents, also allowed reformists to invoke the supposed lapses of modern Buddhism to promote a vision for increased social engagement. The imagining of a “golden era” authorized and naturalized Buddhist social engagement while the call for reform provided a sense of urgency. Without establishing their expertise, Buddhists would be forced to make the argument for modern social engagement from scratch. Without the sense of a modern crisis, present-day Buddhists would lack a key motivation for social engagement. The way in which Inoue looked back to the Buddhist “golden era” while simultaneously bemoaning modern “degeneration” has continued to color scholarship on contemporary Buddhism as well.¹⁵ This also shows us the reason why a twentieth century Zen

¹⁴ *Kyūsai* 1, no. 1 (1911), [ii], 1.

¹⁵ As Mark Rowe notes, the “give it your best, Buddhism!” (*gambare Bukkyō!*) approach of scholars who highlight the innovative activities taken by a few contemporary Buddhists only serves to amplify the narrative of degeneration. “Charting Known Territory: Female Buddhist Priests,” *Japanese Journal of Religious Studies* 44, no. 1 (2017): 77-78.

priest aims to be a doctor: the fear that twenty-first century parishioners will otherwise, “only expect us to conduct funerals and memorial services.”

Rites to Care for the Dying

Although invoking past examples of social welfare activities more broadly informs the promotion of modern Buddhist medical welfare, a more specific inspiration for Buddhist contemporary engagement in contemporary hospice and spiritual care comes from the pre-modern Buddhist practice of “deathbed rituals” (*rinjū gyōgi* 臨終行儀) that provided dying persons in medieval and early modern Japan with a set of ritual tools to maintain a state of right mindfulness (*shōnen* 正念) at the moment of their death to ensure an auspicious rebirth in the next life. To ensure right mindfulness, a spiritual companion called a “good friend” (*zenchishiki* 善知識) often assisted the dying by helping them to chant the Buddha’s name (*nenbutsu* 念佛) in their last days and hours, providing encouragement, and managing the deathbed environment so that it was conducive to right mindfulness.¹⁶ What makes these premodern deathbed rites especially appealing to modern proponents of spiritual care is the image of a Buddhist priest helping dying persons reach a state of spiritual equanimity during their last days. For instance, a collection of *rinjū gyōgi* texts edited by one of the founders of the Vihāra movement makes a direct correlation between these practices and hospice care in a book titled: *Rinjū Gyōgi: The Origins of Japanese Terminal Care*.¹⁷ The former head of the Nichiren Vihāra Network also refers to the early seventeenth century *rinjū gyōgi* text *Chiyo migusa* 千代美草 as having,

¹⁶ Jacqueline I. Stone, *Right Thoughts at the Last Moment: Buddhism and Deathbed Practices in Early Medieval Japan* (Honolulu: University of Hawai‘i Press, 2016).

¹⁷ Kamii Monshō et al. eds., *Rinjū Gyōgi: Nihonteki tāmīnaru kea no genten* (Tokyo: Keisuishā Hatsubai Hōkushindō, 1993).

“content rich in suggestions for us today despite its historical background in the early Edo period,”¹⁸ while another contemporary study of esoteric *rinju gyōgi* suggests that both medieval *rinju gyōgi* and contemporary palliative care share the common goal of seeking a “desirable death.”¹⁹

At one level it may seem strange that modern Buddhists are seeking to distance themselves from the image of “funerary Buddhism” by stressing their historical expertise in caring for the dying. After all, is not care for the dying, with all its concomitant rituals of separation and liminality, arguably on the same continuum as care for the dead?²⁰ In the case of hospice care, however, one primary difference is monetary. Since funerary rituals are notoriously expensive in Japan, the Buddhist priest is often cast in the popular media as a greedy figure that only appears at the parishioners’ homes after they die.²¹ In contrast, the Vihāra movement has thus far shown an absence of financial motives and relies heavily on the work of volunteers.

However, the comparisons between *rinju gyōgi* and contemporary hospice care also generate confusion on the role of contemporary Buddhists in spiritual care. To be sure, drawing attention to the history of *rinju gyōgi* helps to show that Buddhist priests were historically more than just postmortem ritualists. But *rinju gyōgi* are also very different from the practice of spiritual care in contemporary hospices. For example, medieval *rinju gyōgi* texts often instruct the accompanying priest to exclude family members from the deathbed since their presence

¹⁸ Shibata Hirohiko, “Den Nichion ‘Chiyo Migusa’ ni kiku bihara katsudō no rinen to jissen,” *Kyōkagaku ronshū* 2 (March 2002): 44-50, accessed January 1, 2012, http://www.genshu.gr.jp/DPJ/kyouka/02/02_044.htm.

¹⁹ Saito Masae, *Mikkyō ni okeru rinjūgyōgi no tenkai* (Tokyo: Nonburu, 2008), 6. For a broader discussion of how Buddhism is particularly suited for hospice care, see Mizutani Kōshō ed. *Bukkyō to tāminaru kea* (Kyoto: Hōzōkan, 1996).

²⁰ Arnold Van Gennep, *The Rites of Passage* (Chicago: University of Chicago Press, 1961).

²¹ For example, in a memorable scene from Itami Juzo’s 1984 film *Osōshiki*, the Buddhist priest arrives in a very fancy car to conduct a funeral.

might arouse thoughts of emotional attachment and thus hinder the dying from attaining right mindfulness. Such instructions show how *rinju gyōgi* arose out of soteriological concerns that emphasized an auspicious rebirth, rather than the contemporary hospice ideal of a painless, gentle death, where caring family members surround the patient. The perceived soteriological stakes in *rinju gyōgi* were also much higher than today. Premodern Japanese were well aware that not dying in a state of right mindfulness opened the possibility of being reborn into the hells or other undesirable realms. Finally, despite the preponderance of textual evidence in the premodern period that suggests the importance of *rinju gyōgi*, it is unclear to what extent Buddhists were actually successful in mastering the art of being a “good friend” to those who were dying. The role of a *zennchishiki* required considerable experience—the kind of hands-on experience that very few Buddhist priests have today. Nonetheless, since *rinju gyōgi* provide the closest pre-modern analogy to spiritual care, they are often invoked as the origins of Japanese Buddhist hospice care.

Examining the ways in which modern Buddhists have mobilized premodern examples of social work, as well as *rinju gyōgi*, to support a reformist vision of modern Buddhist engagement in medical welfare and especially care for the dying, helps show us the discursive context for the modern hospice movement. The imaginings of a “golden era” in which Buddhists were more active in providing care to the sick and dying helps to legitimize Buddhist expertise and also calls attention to their modern “failures.” Locating the starting point of hospice care in *rinju gyōgi* is also important for Buddhist groups since it looks outside Christian-influenced models of spiritual care. As the next section will show, Christian groups played a key role in the founding of religious hospitals in Japan during the early twentieth century which subsequently led to their formative role in the hospice care movement.

Medical Missions and the Establishment of Religious Hospitals in Japan

The Impact of Christian Medical Missions

Although Buddhism may have a longer history of medical welfare activities in Japan, a case could be made that Christian medical missions in modern Japan have had a much stronger impact on the subsequent development of hospice care. This is quite remarkable in light of the fact that Christians have never constituted more than a few percent of Japan's population.²² The initial impact of Christian medical missions can be traced to the period 1823-1910, when it is estimated that more than two hundred Western medical workers made their way to Japan to practice medical care. Nearly a third of these workers who arrived during the Meiji period were Christian medical missionaries.²³ Although the rapid acquisition of Western medicine by Japanese eventually eclipsed the importance of medical missions, the impact that medical missionaries made was indelible. Not only did missionaries found many medical institutions that are still open in Japan today, but their example helped spur the development of Buddhist medical welfare as well.²⁴

²² In 2015, less than 2 million of Japan's 127 million residents identified as Christian. Portal Site of Official Statistics of Japan, "Zenkoku shajikyōkaitō shūkyōdantai, kyōshi, shinjasū," last modified December 31, 2015, accessed December 7, 2017, <http://www.e-stat.go.jp/SG1/estat/Xlsdl.do?sinfid=000031522331>.

²³ Of the total number of medical workers, three-quarters were doctors and the remainder included other workers such as nurses, dentists, pharmacists, teachers and caregivers for lepers. The medical missionaries represented over twenty different denominations with the greatest number being sent out by the Protestant Episcopal Church, the American Board of Commissioners for Foreign Missions, and the Presbyterian Church in the United States. For a list of medical missionaries during this period see, Soda Hajime, et al. eds., *Igaku kindai to rainichi gaikokujin*, (Osaka: Sekai Hoken Tsūshinsha, 1988), 155-173. For a historical overview and timeline of Christian social and medical work in Japan, consult Abe Shirō and Okamoto Eiichi eds, *Nihon kirisutokyō shakaifukushi no rekishi* (Tokyo: Minerva, 2014); and Yajima Yutaka, *Meijiki Nihon kirisutokyō shakai jigyō shisetsushi kenkyū* (Tokyo: Yūzankaku Shuppan, 1982). Also, Elisheva Avital Perelman, "The Exponent of Breath: The Role of Foreign Evangelical Organizations in Combating Japan's Tuberculosis Epidemic of the Early 20th Century" (PhD diss., Berkeley University, 2011); Hamish Ion, *The Cross and the Rising Sun Volume 2* (Waterloo, Ont: Wilfrid Laurier University Press, 1993), 177-179.

²⁴ Yoshida Kyūichi, *Nihon shakai jigyō no rekishi* (Tokyo: Keisō shobō, 1994), 109.

By 1883, eighteen Christian medical missionaries had arrived in Japan, but it was not certain if they were really needed.²⁵ In the report on “The Position of Medical Missions” made by Theobald Palm of the Edinburgh Medical Mission at the 1883 General Conference of Protestant Missions held in Osaka, he makes clear that Japan was not a typical field for medical missions.

A medical missionary is generally sent to people destitute of medical assistance. In Japan, however, this is not the case... Of the recent efforts of the Government of this country to promote a national and scientific practice of medicine by the establishment of medical schools and hospitals and the employment of foreign teachers, and of the degree of success attending them, it is unnecessary for me to speak. Probably in no department have foreign ideas and practices been so well assimilated as in this...Hence, while in many countries a medical missionary would be besieged with applicants for relief as soon as the report of a few successes becomes known, in Japan he finds himself in competition with a Government Hospital which probably has a European medical officer at its head, or, if not, a staff of well-trained Japanese physicians.²⁶

As Palm's report makes clear, Japan had little need for medical missionaries. In the discussion that followed Palm's 1883 report, James C. Hepburn, a senior medical missionary also agreed that “Japan at present day was not a field for medical missions.”²⁷

The view that medical missions were no longer requisite in Japan was confirmed seventeen years later at the 1900 General Conference of Protestant Missions held in Tokyo. There, Wallace Taylor, a doctor and missionary sent out from the American Board of Commissioners for Foreign Missions, noted that while medical assistance had been helpful in the

²⁵ Ono Naoka, “Rainichi iriyō senkyōshi to Meiji zenki no Nihon no iriyō: 1883 nen Osaka senkyōshikaigi gijiroku kara,” *Bukkyō daigaku sōgō kenkyūjo kiyō* 12 (2005): 36.

²⁶ Theobald Palm, “The Position of Medical Missions,” in *Proceedings of the General Conference of the Protestant Missionaries of Japan Held at Osaka, Japan, April, 1883* (Yokohama: R. Meiklejohn & Co., 1883), 317.

²⁷ James Hepburn also records that he averaged about one hundred patients a day when he opened his first dispensary in 1861. Later in 1867, he reduced his hours to a few hours in the morning and saw an average of fifteen to twenty patients daily. By 1876, his dispensary was only open on Saturday with an average of sixty patients per week. J.C. Hepburn and Michio Takaya, *The Letters of Dr. J.C. Hepburn* (Tokyo: Tōshin shobō, 1955), 48, 93, 141.

past, now, such assistance would “not only be considered of doubtful propriety but would be a burden rather than a help.”²⁸ He added that whereas Japanese patients were previously attracted to medical missionaries because they believed them better qualified than Japanese doctors, the large number of competent and qualified Japanese doctors now had removed the necessity for foreign physicians. In contrast to Palm, however, Taylor goes on to qualify his remarks by suggesting a need for medical work *amongst the poor*.²⁹ Although Palm had warned seventeen years earlier against introducing a “pauperizing system into Christian hospitals,” Taylor presents a favorable view of charity hospitals.³⁰

Hence the field and opportunity for medical charities is large and wide in Japan, and the desirability, if not the necessity, of establishing medical charities that will be a laudable example for the developing Christian communities to follow; and a stimulus to the government and the people in general to provide in some adequate measure for and to care for their sick-poor and those unfortunate classes, the blind, the deaf and dumb, the insane and the leper, is equally desirable.³¹

Taylor calculated that where the expenditures for medical charities in the United States were about one dollar per unit of the population, in Japan expenditures amounted to a mere one-sixth of a cent. To illustrate the immensity of the need for charitable medical care in Japan, Taylor further noted that the Presbyterian Hospital in New York had run a deficit of \$80,000 in 1898, a good portion of this amount representing its medical charities. This sum, he said, exceeded the amount expended on medical charities in the whole Japanese empire.³² Taylor went on to claim, “Japan has scarcely made more than a beginning in the highest form of civilized and Christian

²⁸ Wallace Taylor, “Medical Work: Its Results and Prospects,” in *Proceedings of the General Conference of Protestant Missionaries in Japan Held in Tokyo October 24-31, 1900* (Tokyo: Methodist Publishing House, 1901), 538.

²⁹ Taylor, “Medical Work,” 543.

³⁰ Palm, “The Position,” 320.

³¹ Taylor, “Medical Work,” 545.

³² Taylor estimates that the total amount spent on medical charity in the Japanese empire (pop. 44 million) was between \$72,500-\$75,000. This compares to \$50,000,000 for the United Kingdom (pop. 39 million) and \$80,000,000 spent for the United States (pop. 80 million). *Ibid.*, 545.

benevolence, that of medical charities.”³³ In conclusion, he argued that, while small-scale medical missionary work had been appropriate in years past, the real need in Japan was for medical charities.³⁴ In the following decades, many missionaries and Japanese Christians responded to Taylor’s call to establish medical charities that could stand as witnesses to Christian benevolence.³⁵

Buddhist Medical Missions

Although Christian medical missionaries were playing a prominent role in Meiji era religious medical work, Buddhist groups were not far behind. For example, the establishment of the Kyoto Ryō Hospital in 1872 was only made possible with the support of Buddhist leaders of the Jōdo and Rinzai sects and the first public psychiatric hospital was established on the temple grounds of Nanzenji in 1875.³⁶ Beginning in the late 1880s, a string of Buddhist dispensaries began offering medical relief.³⁷ In 1909 for instance, the Saisei Hospital was established on the

³³ He does mention several exceptions: “Dr. Ando of Kioto has kept up a free Charity Dispensary for the poor and indigent for the last seventeen years,” as well as the Charity Hospital of Tokio, (*Jikei Byoin*), another free hospital for the poor and indigent. Taylor, “Medical Work,” 546.

³⁴ Drummond also indicates “by the early 1880’s medical missions had become primarily a benevolent service to the poor.” Richard Henry Drummond, *A History of Christianity in Japan* (Grand Rapids: William B. Eerdmans Publishing Company, 1971).

³⁵ For example, missionaries Hannah Riddell and Nellie Cornwall Legh pioneered leprosaria in Kyūshū and Kusatsu; A.M. Tapson founded a home for tubercular patients in Tokyo, and John G. Waller helped build what would later become New Life Hospital in Nagano in 1932. The Salvation Army also built two hospitals in Tokyo in 1916 and 1939. Hasegawa Tamotsu, who was inspired by the work of Christian social relief activists like Ishii Jūji and Kagawa Toyohiko, also helped found the Seirei Mikatahara Hospital in 1930.

³⁶ Nakanishi Naoki, *Bukkyō to iryō fukushi no kindaishi* (Kyoto: Hōzōkan, 2004), 21-22.

³⁷ In 1890, the Buddhist Charity Association (*Bukkyō jizenkai*) was formed to provide relief to those who could not afford medical care. Other examples include the Hakonishi Dōwakai Seyakuin in Shizuoka (1889); the Hijiri Kai in Aichi (1890); the Kyoto Seyakuin (1890); the Dainihon Seyakuin in Nagoya (1893). Nakanishi, *Bukkyō to iryō*, 23-27; *Meikyō shinshi*, July 20, 1890. Buddhist charity associations established include: *Dai Nihon Bukkyō Jizenkai Zaidan* (Shin Jōdo Honganji sect, 1901); *Ōtaniha Jizen Kyōkai* (Shin Jōdo Ōtani sect, 1911), and the *Jōdo Hōon Meishōkai* (Jōdo sect, 1914). Nakanishi, *Bukkyō to iryō*, 146.

grounds of Tōji temple in Kyoto by the Shingon association Sofū Senyōkai 祖風宣揚会 (lit. “Association for Enhancing our Founder’s Teachings”) and became one of the most prominent Buddhist charity hospitals established in the Meiji period.³⁸ The Sofū Senyōkai had itself been established six years earlier by reform minded Buddhists aiming to expand their religious influence, bring about Buddhist prosperity, and reform society. One of the leaders of the Sofū Senyōkai described the mission of the new charity hospital as: “Recognizing the common evil of the divergence between religious faith and the medical world, [our mission is] to heal the illnesses of the body and *kokoro* 心 (heart/mind) through the mutual interdependence of the medical way and religion.”³⁹ Their efforts were quite successful. In its first four years, the Saisei Hospital treated 18,159 new patients.⁴⁰

As did their Christian counterparts, many Buddhists framed the importance of their medical work as acts of charity. For example, the Saisei Hospital declared itself willing to follow the example of its Shingon patriarch Kūkai 空海 in practicing compassion and saving the world (*jiai saisei* 慈愛濟世) by not seeking payments from patients, although sincere donations would be accepted.⁴¹ These Buddhist forays into medical charity especially intensified especially after 1911. In February of that year, a new Imperial Rescript announced an imperial donation of one

³⁸ Yoshida Kyūichi, *Nihon kindai bukkyō shakaishi kenkyū (ge)* (Tokyo: Kawajima Shoten, 1991), 138.

³⁹ Ibid., 139.

⁴⁰ *Kyūsai* 4, no. 3 (1914): 50.

⁴¹ Yoshida, *Nihon kindai bukkyō (ge)*, 139. In 1902, the Jūzen Hospital in Tokyo was also launched with Shingon backing and provided subsidized medical treatment for needy patients. Nakanishi, *Bukkyō to iryō*, 36-37; Yoshida, *Nihon kindai bukkyō (ge)*, 141. In the same year, the Nihon Hinmin Hospital was founded by Yoshida Eryū, an apprentice to a Nichiren priest with the express purpose of treating the destitute. Nakanishi, *Bukkyō to iryō*, 37. Likewise, in 1911, the Waseda Hospital was established by the Jōdo Shin sect and began subsidizing treatment for needy patients. Yoshida, *Nihon kindai bukkyō (ge)*, 142. Other examples of Buddhist charity hospitals include the Teikoku Kyūjoin (Shin Jōdo, 1907); Sensōji Hospital (Tendai, 1910); the Higanin (Shingon, 1914); and the Bukkyō Kyōsaisha Hospital (Sōtō, 1914). Nakanishi, *Bukkyō to iryō*, 58-62.

and a half million yen for the establishment of the Saisei Association (*Saiseikai* 済生会) to provide medical services to the poor and needy of Japan. This event was widely reported on in the media and helped spur Buddhists to do even more in providing medical relief, including the publication of the Buddhist journal on social welfare *Kyūsai* between 1911 and 1919.⁴²

Outdoing the Other: Christian and Buddhist Medical Welfare

As this flurry of activities by both Christians and Buddhists suggests, the Meiji period was a formative moment for Japanese religious engagement in modern medicine. For Buddhists in particular, the sense that Christians were outdoing them in the area of charitable activities remained an important motivating force for social engagement.⁴³ Christian missionaries also lambasted Buddhists for not doing enough. In 1915, Sidney Gulick, a Christian missionary lamented Buddhist inactivity while also drawing on the discourse of Buddhist “decay.”

With the decay of Buddhism in recent centuries, however, little philanthropic activity has survived. With the revival of Buddhism, Buddhists have again undertaken philanthropic work; they have established orphan asylums, schools, ex-convict homes, and various benevolent enterprises for the poor, the old, and invalids; but not yet do they seem to appreciate the moral and industrial situation, or undertake anything commensurate with their numbers and resources.⁴⁴

Such statements paint a pessimistic picture of Buddhist social engagement in this period but must be assessed carefully. According to Yoshida Kyūichi, there were approximately 485 Buddhist social welfare institutions by the end of the Meiji period (1912).⁴⁵ On the Christian side, Yajima

⁴² Yoshida, *Nihon kindai bukkyō (ge)*, 137-138.

⁴³ Nawa Tsukinosuke, “Meiji chūki ni okeru bukkyō jizen jigyo no keisei ni tsuite,” *Shitenōji Kokusai Bukkyō Daigaku kiyō* (2004): 29-44.

⁴⁴ Sidney L. Gulick, *Working Women of Japan* (New York: Missionary Education Movement of the United States and Canada, 1915), xi-xii.

⁴⁵ Yoshida Kyūichi, *Nihon kindai bukkyō shakaishi kenkyū* (Tokyo: Yoshikawa Kōbunkan, 1964). Of these, twenty-four are listed as providing medical care and fifteen as medical dispensaries. Four of the medical institutions were located in Japan’s overseas colonies of Taiwan and China.

Yutaka counts only 124 Christian social welfare institutions that were founded during the same period.⁴⁶ Other historians have reached different figures, but all agree that the number of Buddhist institutions exceeded their Christian counterparts by no small margin during the first few decades of the twentieth century.⁴⁷ In terms of medical institutions specifically, however, it seems that the Buddhist efforts did lag behind Christians. As Nakanishi Hiroki notes, the Jōdo sect embraced the slogan, “one temple, one social service” (*ichi jiin ichi jigyo* 一寺院一事業) in the 1930s, but in reality most temples could at best only afford to provide religious edification or education activities (*kyōka katsudō* 教化活動) and local childcare.⁴⁸ Therefore, although the actual number of social welfare institutions within the Jōdo sect more than tripled between 1922 and 1939, the majority of these institutions were restricted to religious education activities or childcare, and less than one percent of the listed institutions provided medical care.⁴⁹

The numbers also do not reflect the overall quality of social welfare activities. For instance, Christian missionary Wallace Taylor bemoans the lack of asylums for the blind, deaf, and dumb and homes for lepers in his report to missionaries in 1900. Although he acknowledges

⁴⁶ Murai Ryūji builds on Yajima’s list to record 155 Christian institutions during the Meiji period. Twenty-five are listed as providing medical care but he does not record the number of dispensaries. Murai Ryūji, “Bukkyō shakai fukushi gaku ni okeru jinbuntsushi kenkyū: Meijiki bukkyō jizen jigyo jissensha o chūshin ni,” *NBSFG* 22 (Oct. 1991): 161-174.

⁴⁷ According to Morinaga, in 1917, Buddhist social work institutions outnumbered Christian ones 140 to 90. By 1930, they outnumbered Christian facilities 4,848 to 1,493. Morinaga Matsushin, *Bukkyōsha no shakai fukushi katsudō*, in *Gendai Bukkyō o shiru daijiten*, ed. Gendai Bukkyō o Shiru Daijiten Henshū Iinkai (Tokyo: Kinkasha, 1980), 371. See also Covell, *Japanese Temple Buddhism*, 99-101. Nakanishi Naoki finds a similar disparity: in 1920, there were 387 Buddhist social work organizations. By 1926, this number had more than tripled to 1,234, and by 1929, the number quadrupled to 4,849. Significantly, in 1920, only 39% of these organizations were sectarian. However, the number of sectarian organizations rose to 48% in 1926 and then to 88% in 1929. The large jump in numbers between 1926 and 1929 was due to the inclusion of the additional categories of educational activities (476) and *kyōka katsudō* (3,042) in the 1929 survey. Nakanishi Naoki, Takaishi Fumito, and Kikuchi Masaharu eds., *Senzenki bukkyō shakai jigyo no kenkyū* (Tokyo: Fujishuppan, 2013), 7-12.

⁴⁸ Nakanishi et al., *Senzenki Bukkyō*, 70-71.

⁴⁹ Nakanishi et al. *Senzenki Bukkyō*, 64

that such asylums exist, he dismisses them on the basis that “when we come to visit these institutions, and inquire into their organization, and learn upon what conditions patients are received, we are forced to the conclusion that they are not medical charities in any legitimate sense of the word.”⁵⁰ Even if Taylor were not biased in his report, it is likely that both the numbers and descriptions of social welfare activities by religious groups fail to reflect the more complicated reality on the ground. For instance, during this period many Buddhist temples were still recovering from the financial and political pressures brought about by government policies that had triggered the “eradication of Buddhism” movement (*haibutsu kishaku* 廃仏毀釈) in the early Meiji period.⁵¹ In some cases, Christians literally “filled in” for the Buddhists by establishing social welfare institutions in vacant temples.⁵² The combination of Buddhist financial struggles, and the support that Christian medical missionaries enjoyed from the foreign community thus helped create an opportunity for the establishment of a large number of Christian medical institutions in early twentieth-century Japan.

While it is difficult to assess exactly how much Buddhists and Christians were in competition with each other, there is certainly evidence to suggest that they were aware of each other’s activities.⁵³ We also see that while Christians played a prominent role in establishing

⁵⁰ Taylor, “Medical Work,” 547.

⁵¹ Martin Collcutt, “Buddhism: The Threat of Eradication,” in *Japan in Transition: From Tokugawa to Meiji*, Marius B. Jansen and Gilbert Rozman eds. (Princeton: Princeton University Press, 1986), 143-167; James Edward Ketelaar, *Of Heretics and Martyrs in Meiji Japan: Buddhism and Its Persecution* (Princeton: Princeton University Press, 1990), 43-83.

⁵² For example, James Hepburn opened his first dispensary and hospital at Shūkōji temple in 1861, and Ishii Jūji began his well-known orphanage on the grounds of Sanūji temple in Okayama in 1889. Hepburn and Takaya, *The Letters*, 44-45.

⁵³ There was certainly no short supply of general antagonism between Buddhists and Christians. In 1892, the philosopher Inoue Tetsujirō published a piece in a journal that accused Christianity of being unpatriotic and inferior to Buddhism. This piece sparked a backlash and a flurry of published responses by Christians that were returned in kind by Buddhists. Yoshida Kyūichi, *Nihon kindai bukkyōshi kenkyū* (Tokyo: Kawashima Shoten, 1992), 202-249.

medical institutions, Buddhists were not far behind, and in terms of the overall number of general social welfare institutions, Buddhists had a much larger presence on the ground. More importantly, we can see that there was a groundswell in the number of social welfare institutions during the 1920s and 30s that indicate Buddhists were taking the call for modern reform seriously, and that they were making inroads into medical spaces.

Religious Medical Welfare in the Postwar Japan

The devastation left in the wake of the Second World War also gave rise to new opportunities for medical welfare by religious groups. For instance, in 1955, Presbyterian missionaries helped to establish Yodogawa Christian Hospital in a historically poor area of Osaka.⁵⁴ Yodogawa Christian Hospital would later become a well-known hospital and leader in the hospice care movement. However, at the time, not all local Japanese doctors welcomed the establishment of such hospitals. In 1953, the head of the local medical association sent a letter to the Presbyterian Church in the United States asking them to reconsider their plans for the hospital on the grounds that it “threatens the living of those who are practicing medicine” and “inserts confusion into the medical system of Japan.”⁵⁵ In a letter defending the project to the Presbyterians back home, the lead medical missionary explained that the Welfare Ministry, as well as U.S. Occupation officials in Tokyo, had encouraged them to pursue this project and that the selection of the site was made in consultation with the Osaka prefecture health department. According to local officials, the selected location for Yodogawa Christian Hospital was a very

⁵⁴ For a brief history of Yodogawa Christian Hospital, see Sophia Montgomery Crane, *A Legacy Remembered: A Century of Medical Missions* (Franklin, TN: Providence House Publishers, 1998), 393-409.

⁵⁵ Dr. K. Kimura to Rev. R.E. Price, May 6, 1953, Presbyterian Church in the U.S. Japan Mission Records, RG 491, Presbyterian Historical Society, Philadelphia (hereafter cited as Japan Mission Records).

needy area with a significant deficiency of hospital beds. The missionary also argued for the establishment of the hospital on the grounds of charity.

Of course we do not expect a profit nor do we think any hospital out here should have any profits. We expect to use our mission subsidy to help carry the charity work we feel is so badly needed. We also expect to charge private paying patients enough to help with this free work. However, we have assured the local doctors that we will not be a “cut rate” institution and will be extremely careful about who we take as charity or part charity cases.⁵⁶

In a letter of reply to the local medical association, the missionaries attempted to assure local doctors that the hospital would only start with about twenty beds and not attempt to compete with local medical facilities but endeavor to be “of aid” for “unmet needs.”⁵⁷ Local doctors were initially skeptical but by 1958, they had largely changed their minds and even invited Yodogawa Christian Hospital to join the local medical association.⁵⁸

By 1961, however, the rationale of charity as a reason for medical missions had largely dissipated. In this year, National Health Insurance became available to all Japanese citizens, and the establishment of hospitals by religious groups also began to taper off. According to Japan’s 2017 Christian Yearbook, there are currently ninety-three medical institutions in Japan that are affiliated with Christian groups or that publicly state a Christian mission.⁵⁹ Forty-five qualify as hospitals (*byōin* 病院), meaning they have at least twenty beds while the rest are primarily clinics. Of these forty-five Christian hospitals, thirty-four (76%) were established before 1960. These data suggest that, as the Japanese economy revived in the 1960s and health care became accessible to all citizens, Christians scaled back their involvement in establishing new medical welfare institutions. But the hospitals remained. By this point, however, Christian hospitals like

⁵⁶ Frank Brown Jr. to C. Darby Fulton, June 11, 1953, Japan Mission Records.

⁵⁷ C. Darby Fulton to Dr. K. Kimura, June 26, 1953, Japan Mission Records.

⁵⁸ Crane, *A Legacy Remembered*, 401.

⁵⁹ Kirisutokyō nenkan henshū iinkai ed., *Kirisutokyō nenkan 2017* (Tokyo: Kirisutokyō Shinbunsha, 2017), 714-719.

Yodogawa Christian Hospital were less likely to emphasize their charitable mission and more likely to emphasize other goals such as a vision of holistic care and spiritual healing. For example, their mission statement declares:

Yodogawa Christian Hospital is dedicated to the glory of God and the salvation of man through the ministry of healing, bringing the power of love and the highest competence of modern science to bear on the social, physical, mental, and spiritual needs of patients, in the conviction that healing will not be complete until, through Christ, the person is reconciled to God.⁶⁰

This statement was later shortened under the motto of “whole person healing,” which was defined as “a medical ministry in Christ’s love, serving the patient as a total unity of body, mind, and spirit.” The inclusion of “spiritual needs” of patients and the focus on “whole person healing” in this mission statement later helped position Yodogawa Christian Hospital at the forefront of implementing the practice of spiritual care for hospice patients.

On the Buddhist side, medical welfare and charitable activities after the immediate postwar period slowed down as well.⁶¹ Unfortunately, there is no comprehensive list of Buddhist hospitals today but a cursory review of statistics on social welfare published by individual sects suggests a relative paucity of medical institutions.⁶² For instance, in 2006, the Honganji branch of Jōdo Shinshū listed 859 social welfare facilities including 726 nursery schools and 89 elder

⁶⁰ Yodogawa Christian Hospital Website, “Zenjin iryō ni tsuite,” accessed December 7, 2017, <http://ych.or.jp/about/zenziniryou.html>.

⁶¹ Some examples of postwar Buddhist medical work include the Shinshū Social Work Association (*Shinshū Shakai Jigyō Kyōkai*), which helped establish the Obihiro Shinshu Hospital (1949) in Hokkaido. In 1955, Tōdaiji temple also established a foundation for promotion of social welfare and established what would eventually become the Tōdaiji Medical and Educational Center. Ochiai Takashi, “Iryō fukushi,” in *Sengo bukkō shakai fukushi jigyō no rekishi*, ed. Hasegawa Masatoshi (Kyoto: Hōzōkan, 2007), 165-168.

⁶² Hasegawa Masatoshi has also compiled a survey of social welfare institutions across Buddhist sects based on sectarian reports but the numbers seem unreliable. He lists a total of five Buddhist medical institutions but it is not clear why a Red Cross Hospital in Wakayama and elderly daycare center in Osaka are listed as Buddhist hospitals. His sources also only cover up to the year 2000 and omit several Buddhist hospitals. *Sengo bukkō shakai fukushi shisetsu, dantai ichiran; Bukkyōkei shakai fukushi jigyō, katsudō tōkei ichiran* (Chiba, Japan: Shukutoku Daigaku Hasegawa Kenkyūshitsu, 2003).

care facilities. Significantly, no hospitals or clinics were listed.⁶³ In fact, to my knowledge, there are currently only a handful of hospitals today that remain publically affiliated with Buddhist groups.⁶⁴ The reasons for this are not readily apparent. For example, the psychiatric hospital founded at Nanzenji in 1875 later became a private institution and was removed in 1882 due to financial difficulties. Likewise the Juzen Hospital (est. 1902) only remained open for several years. Even the largely successful Saisei hospital at Tōji (est. 1909) was forced to close in 1946. The most probable explanation for these closures is that as public medical care became ubiquitous and affordable for all classes of Japanese society, the need for medical charity became less pronounced and Buddhist groups simply turned their attention to other issues.⁶⁵

In contrast, many Christian hospitals remained open. As mentioned earlier, four of the first five hospices in Japan were established at Christian hospitals, including one of the earliest hospices at Yodogawa Christian Hospital. In 2017, approximately thirty-three Christian hospitals in Japan provided some form of hospice care, and all but nine of these hospices were founded before 1960.⁶⁶ Many of these hospitals employed Christian doctors, had Christian mottos that emphasize spiritual as well as physical healing, and already had hospital chaplains on staff who were available to lead chapel services and visit patients. This existing infrastructure, plus the ties

⁶³ Funamoto Yoshie, “Bukkyōkei shakai fukushi shisetsu no genjō to bukkyō shakai fukushi jissen no shisōteki kiban: Jōdo shinshū honganjiha shakai fukushi shiestsu jittai chōsa hōkoku (gaiyō),” in *Gendai ni ikiru bukkyō shakai fukushi*, ed. Hasegawa Miyuki (Kyoto: Hōzōkan, 2008), 200.

⁶⁴ Examples include the Asoka Hospital (est. 2008) and Sensōji Hospital (est. 1952) in Tokyo, as well as three Buddhist hospices that will be discussed in the next section.

⁶⁵ Yagi Seiya, “Tōji Saisei Byōin no hensen,” *Itan*, no. 96 (2012): 89.

⁶⁶ Of these Christian hospices, fourteen were established at hospitals established in the prewar period (1889-1945). These data were compiled from the *Kirisutokyō Nenkan 2017*, and the July 2017 list of hospice facilities on the Hospice Palliative Care Japan Website, accessed July 2017, <http://www.hpcj.org/list/relist.php>. I am also deeply indebted to Prof. Taniyama Yōzō for sharing his personal list of religious hospices with me.

with North America and Europe that many Christian hospitals held through their missionary heritage, were instrumental in paving the way for the establishment of hospice care.

Overall, during the long twentieth century, we can see how both Buddhists and Christians were involved in the establishment of hospitals, clinics, as well as other social welfare institutions that showed the “healthy” role they were playing in society. Christian and Buddhist religious groups in Japan initially mobilized and justified their work in medical missions by focusing on the importance of charity (*jizen* 慈善) as both a tenet of religious practice and a symbol of modernization. For example, Christian medical missionaries like Wallace Taylor lauded the opportunity that charity hospitals in Japan provided to stand as “the highest form of civilized and Christian benevolence” and Buddhist intellectuals like Inoue Enryō criticized the Japanese Buddhists for their “lack of charitable work.” Eventually the rapid acquisition of Western medicine by Japanese in the prewar period, and the extension of national health insurance in the later postwar period eclipsed the importance of medical missions as a form of charity. But many of the prominent Christian hospitals remained. These hospitals often had mission statements or mottos that emphasized “spiritual healing” and “whole person care” as part of their medical services. As the next section will show, these hospitals became important sites for the introduction of hospice care and the development of a philosophy of spiritual care as well.

The Birth of Hospice Care in Japan

This final section will briefly outline the history of the hospice movement in Japan with special attention to the role played by religious groups. As suggested earlier, Christians played an especially important role in pioneering hospice care and helped shape spiritual care in important ways. I will first outline their contributions before turning to examine the Buddhist hospice or

Vihāra movement. I will also discuss how growing public attention to the practice of *kokoro* care in the aftermath of the 1995 Hanshin earthquake helped opened the path for the practice of spiritual care in medical spaces by mainstreaming and socializing psychotherapeutic practices more broadly in Japanese society. 1995 was also an important cultural moment in which religious groups more broadly felt a renewed emphasis to engage in “healthy” activities due to their deteriorating public image after the Aum Shinrikyō sarin gas attacks. These historical events and cultural currents are integral to understanding the broader context of religious involvement in medicine and the heightened attention to the topic of spiritual care for the dying.

The Introduction of Hospice Care in Japan

Interest in establishing a hospice in Japan first began to gather momentum in the 1970s, and it received a boost after Elizabeth Kübler-Ross’s best selling book, *On Death and Dying* (1969) was translated into Japanese in 1971. One of the key figures in the Japanese hospice movement was Kashiwagi Tetsuo 柏木哲夫 (1939-), a Christian psychiatrist who worked at Yodogawa Christian Hospital. In 1973, a year after Kashiwagi returned from a medical residency at Washington University in St. Louis, he encountered a terminally ill patient whom he referred to as S. The patient was experiencing extreme anxiety about death and was referred to Kashiwagi by a colleague who asked for help. As he spoke with S, Kashiwagi realized that no one doctor could treat this patient, who was facing a range of issues including severe physical pain, psychological anxiety, family and financial issues, as well as spiritual anxiety. It was at this moment that he recalled something he had learned in the United States called “The Organized Care of the Dying Patient.” Kashiwagi determined to create a similar team at Yodogawa Christian Hospital that included a doctor, nurse, social worker, psychiatrist, and a chaplain to

meet weekly and discuss patients' needs. This was, Kashiwagi claims, the beginning of hospice care in Japan.⁶⁷

In 1979, 1980, and 1981, Kashiwagi was sent by Yodogawa Christian Hospital to visit and receive further training at several hospices in Britain and the United States. There he learned about hospice care directly from figures like Dame Cicely Saunders of St. Christopher's Hospice, who was considered the founder of modern hospice care. Kashiwagi explains that during his visits, Saunders checked his impulse as a Christian psychiatrist to focus mainly on the spiritual and psychological aspects of hospice care. Kashiwagi recounts the following advice from Saunders:

Let's say that I was diagnosed with cancer and went to a hospital. The first thing I would want is not for an experienced psychiatrist to listen to my irritated feelings or a chaplain to pray that my pain will go away quickly. I would first want a proper diagnosis of what is causing my pain; followed by a determination of what would be the best medical drug, dosage, schedule, and method of administration. As a Christian psychiatrist, it is splendid that you yearn to build a hospice. But this is not enough for a patient to endure pain. You cannot do this as a psychiatrist. It is important to have faith, but prayer alone is not enough to take away pain.⁶⁸

According to Kashiwagi, these words had a great impact on him. After he returned to Japan, he undertook further medical training in internal medicine while also raising funds for building a hospice. Kashiwagi also drew attention to hospice care by publishing a book in 1978 on team approaches to care for the dying, and laid out a vision for hospice care in a 1983 book that went through fifteen printings in the first three years.⁶⁹ This marked the beginning of Kashiwagi's prolific publishing career that has proceeded at the pace of about one book per year.

In the meantime, others in Japan were beginning to become active in promoting hospice care. In 1974, Kawano Hiroomi 河野博臣 (1928-2003), a Christian physician, published a book

⁶⁷ Kashiwagi Tetsuo, *Teihon hosupisu, kanwa kea* (Tokyo: Seikaisha, 2006), 14-15.

⁶⁸ Ibid., 38-39.

⁶⁹ Kashiwagi Tetsuo, *Sei to shi o sasaeru: Hosupisu kea no jissen* (Tokyo: Asahi shinbunsha, 1983).

on support for the dying and in 1978, he founded the Japanese Association for Clinical Research on Death and Dying (JARD), which continues to host Japan's flagship conference on hospice care. In the same year, the Japan Society for Dying with Dignity was established and the establishment of hospice care was set as one of its goals.⁷⁰ Finally, Japan's first official hospice opened in 1981 at Seirei Mikatahara Hospital in Shizuoka. Seirei Mikatahara Hospital was originally founded by the Christian activist and politician Hasegawa Tamotsu 長谷川保 (1903-1994) in 1930, and the hospital continues to uphold the motto of "neighborly love based on the Christian spirit."⁷¹ After gathering sufficient funds, Yodogawa Christian Hospital opened Japan's second hospice three years later in 1984. Notably, to this day Yodogawa Christian Hospital legally remains a religious organization (*shūkyō hōjin* 宗教法人) under the jurisdiction of the Presbyterian Church, U.S.A., and staffs several full time chaplains who visit patients and conduct chapel services while upholding the motto of "whole person healing." Moreover, since both Seirei Mikatahara Hospital and Yodogawa Christian Hospital already had Christian chaplains on staff, the availability of chaplains to join the hospice team allowed them to begin practicing spiritual care immediately.

In 1987, Japan's third and first non-religious hospice opened at Kokuritsu Ryōyōjo Matsudo Hospital, which was a public hospital that eventually became part of the National Cancer Center in Chiba. In contrast to the first two Christian hospitals, at Kokuritsu Ryōyōjo Matsudo, as a public hospital, it was reportedly difficult for religious workers to be involved in the care of patients. Instead, they reportedly made sure to provide plentiful greenery and wild

⁷⁰ Fujihara Akiko, "Gendai Nihon hosupisu kō," in *Shūkyōgaku to igaku*, ed. Kuroiwa Takuo (Tokyo: Kōbundō, 1991), 120-145.

⁷¹ Seirei Mikatahara Hospital Website, accessed January 21, 2016, <http://www.seirei.or.jp/mikatahara/outline/480.html>.

birds to help patients relax their hearts and minds (*kokoro*).⁷² In 1989, a fourth hospice was begun at the Christian Salvation Army Kiyose Hospital in Tokyo, and in 1990, a doctor who also served as a local Christian minister established Japan's fifth hospice at Eikoh Hospital in Fukuoka. After April 1990, when hospice care fell under the aegis of Japan's National Health Insurance, the number of hospices grew rapidly. In that year, the physician Yamazaki Fumio 山崎章郎 also published his national best seller, *Dying in a Japanese Hospital* (*Byōin de shinu to iu koto* 病院で死ぬということ), which deplored the medicalization of death in hospitals and called for more hospice care. By 1995, the number of hospices had increased to twenty-three, of which nine were affiliated with Christian hospitals. By November 2017, the total number of hospices in Japan had grown to 336. Approximately thirty-three of these remain affiliated with Christian hospitals, most of which employed Christian chaplains who provided spiritual care.⁷³

The Vihāra Movement

On the Buddhist side, the hospice movement unfolded shortly after Christian hospitals began to establish hospices. One of the first essays by Buddhists on this topic was published in the 1984 annual report of the Japanese Buddhist Association for Social Welfare Studies (*Nihon Bukkyō shakai fukushi gakkai*, or NBSFG 日本仏教社会福祉学会), in which the author tackled the subject of what Buddhists could do to help the elderly deal with anxiety over death.

Recently, in the hospices and end of life care institutions that have begun to be built even in our country, there is a demand for religionists to become part of the medical team. Although Christian clergy can participate easily, it is said that it is difficult for Buddhist priests to participate. For example, it is said that there is a resistance to the priest's garb [which is associated with funerals], but if this were really the problem it would be simple enough for priests to visit in their everyday attire. Most likely, it is because even before

⁷² "Makki gan ni ryokuin no byōtō," *Asahi Shimbun*, July 9, 1989.

⁷³ See Appendix I for a full list of Christian hospices.

patients receive support, the feeling of wanting to consult with or receive support from a priest is lacking. Unless a relationship of support in ordinary circumstances is established, it will be difficult to support the *kokoro* (heart/mind 心) at the end of life.⁷⁴

As the hospice movement gathered momentum, articles on the need for religious care of the terminally ill began to appear more frequently in the annual reports of the NBSFG. In 1986, another essay reported on the implementation of religious care in a Buddhist nursing home that included the celebration of Buddhist holidays and a sutra reading club.⁷⁵ In 1988, a survey reported on what eighty-one hospital superintendents and head nurses from hospitals in Kyoto thought of having religious workers serve on medical care teams. Somewhat disappointingly for the author, approximately seventy percent of hospitals felt holding religious services within the hospital was unnecessary, and only ten percent felt it was “absolutely necessary” for religious workers to join the medical team. On the other hand, eighty percent of those surveyed were in favor of religious workers visiting patients who subscribed to a particular religion.⁷⁶ In the same year, the Japanese Buddhist Association for Social Welfare Studies inaugurated a symposium on “Buddhist Social Welfare and Terminal Care” at their annual conference that was repeated in 1990.⁷⁷

The first significant step towards Buddhist involvement in hospice care was taken in 1985, when Tamiya Masashi 田宮仁 (1947--) first used the Sanskrit term “Vihāra” (*bihāra* ビハーラ), to refer to Buddhist hospice care.⁷⁸ The term literally means “abode,” and traditionally

⁷⁴ Nagura Michitaka, “Rōjin no shūmatsu e no fuan to bukkyō shakai fukushi: Anrakushi rongi e no gimon,” *NBSFG Nenpō* 15 (1984): 79.

⁷⁵ Tamiya Masashi, Koyama Tsuyoshi, and Kaneto Yoshiichi, “Bukkyō to rōjin fukushi: Rōjin hōmu ni okeru taminaru kea,” *NBSFG Nenpō* 17 (1986): 53-82.

⁷⁶ Saikō Gishō, “Rōjin, byōnin ni taisuru bukkyō kea,” *NBSFG Nenpō* 19, (1988): 109-118.

⁷⁷ *NBSFG Nenpō* 20 (Oct. 1989): 83; *NBSFG Nenpō* 21 (Nov. 1990): 22.

⁷⁸ According to Tamiya, the first published usage of this term was in his 1986 article: “Bukkyō o haikai to shita hosupisu/bihāra (Vihāra) no kaisetsu o negatte,” *Life Science* 13, no.1 (1986): 56-59.

refers to monasteries, retreats, or places of rest.⁷⁹ Tamiya's vision for this term was to provide an alternative to the word "hospice": a term he saw as carrying Christian associations. For Tamiya, it was essential to stress that Vihāra was not simply an imitation of Christian hospice care but represented a separate tradition of care for the dying that extended back in Japanese history to pre-modern examples of medical welfare and *rinju gyōgi*.⁸⁰ Tamiya also hoped the term would spark a non-sectarian movement. Initially, however, Jōdo Shinshū Buddhists were the most active in orchestrating Vihāra activities.

Tamiya himself was born to a temple family of the Ōtani branch of Jōdo Shinshū and was a scholar of Buddhist welfare at Bukkyō University in Kyoto. In 1986, the Honganji branch of Jōdo Shinshū took the lead by establishing a committee devoted to promoting the Vihāra movement, and in 1987 the non-sectarian Buddhist Information Center (*Bukkyō jōhō sentā* 仏教情報センター) formed the "Buddhist Hospice Association."⁸¹ This group was spearheaded by Koizumi Keishin 小泉敬信 (1949--), a Jōdo Shinshū priest who had lived for thirteen years in Hawaii and observed the work of chaplains in hospices there. During a visit he made to the Christian hospice at Seirei Mikatahara Hospital, one of the doctors asked Koizumi why Buddhists had not opened their own hospice since most of the patients at Seirei Mikatahara Hospital were in fact Buddhists. The secretary of the Buddhist Information Center also expressed concern that Buddhists were shirking their duty, noting, "Buddhism was becoming a religion for the dead rather than the living," and observing, "the Buddhist hospice suited our attempts to

⁷⁹ By choosing a Sanskrit term, Tamiya also—perhaps unconsciously—finds himself in a line of Buddhist tradition legitimating "new" practices by looking back to India. *NBSFG* ed., "Vihāra," in *Bukkyō shakai fukushi jiten* (Kyoto: Hōzōkan, 2006), 254-255; Robert E. Buswell Jr. and Donald S. Lopez Jr. eds. *Princeton Dictionary of Buddhism* (Princeton, NJ: Princeton University Press, 2014), 968.

⁸⁰ Tamiya Masashi, *Bihāra no teishō to tenkai* (Tokyo: Gakubunsha, 2007), 4-5.

⁸¹ Tamiya, *Bihāra no teishō*, 7.

show our concern for the living.”⁸² In Kyoto, where Tamiya was active, the Kyoto Vihāra Association was formed in 1987, and several committees were established to research the feasibility of establishing a Buddhist hospice.⁸³ The Association for Supporting Vihāra also helped raise one hundred million yen for the building of a nonsectarian Buddhist hospice with the support of the president of the Japan Buddhist Federation, and the president of Bukkyō University.⁸⁴ In 1992, their goals were finally realized with the opening of a twenty-two-bed Vihāra ward at Nagaoka Nishi Hospital in Niigata, a hospital whose superintendent was Tamiya Takashi, the younger brother of Tamiya Masashi. In 1993, a Buddhist nursing course was also established in the Department of Buddhist Studies at Bukkyō University.⁸⁵ In Nagoya, Tashiro Shunkō 田代俊孝 (1952-), a professor at Dōhō University, also instituted a group in 1988 that sought to train laypersons to care for those who were dying. Their monthly meetings drew approximately one hundred people and the occasional public seminars drew three times that number.⁸⁶ In Kyūshū, medical doctor Tabata Masahisa 田畑正久 (1949--) began the Kunisaki Vihāra Society in 1990, and helped orchestrate study classes on the *Tannishō* 歎異抄, a work said to record the teachings of the Jōdo Shinshū founder Shinran (1173-1263), as an opportunity to think about death and dying.⁸⁷

⁸² Ritsuko Nakamura, “With Faith, Hope, Love, and Charity: Hospice Movement Seeks to Restore Role of Buddhism,” *Japan Times*, July 27, 1995.

⁸³ In 1989, a preliminary plan and blueprints for a Vihāra ward was even published in the *NBSFG* by three members in the Department of Architecture at Tohoku University. Kanno Minoru, Onoda Yasuaki, and Mase Masahiko, “‘Bihāra’ sono kūkanka e no shiron,” *NBSFG Nenpō* 20 (1989): 91-107.

⁸⁴ Tamiya, *Bihāra no teishō*, 36.

⁸⁵ *Ibid.*, 80.

⁸⁶ Fuki Ikeuchi and Alison Freund, “Japanese Buddhist Hospice and Shunkō Tashiro,” *Buddhist-Christian Studies* 15 (1995): 61-65.

⁸⁷ Ugo Dessi, *Ethics and Society in Contemporary Shin Buddhism* (Berlin: Lit Verlag, 2006), 189.

When Japan's first Buddhist hospice was established in 1992, it was initially greeted with much fanfare and was even featured in a national television documentary.⁸⁸ But despite high expectations, a second Vihāra ward was not established for another decade. In 2004, the lay Buddhist new religious group Risshō Kōseikai, launched a hospice at the Risshō Kōseikai Hospital (est. 1952) in Tokyo. Then in 2008, the Honganji branch of Jōdo Shinshū established Japan's first independent Vihāra hospice ward at Asoka Vihāra Hospital in Kyoto. Finally, in June 2017, a fourth Vihāra ward opened at Megumi Hospital in Fukuoka.

The relatively small number of Vihāra wards established in the thirty years since the Vihāra movement was inaugurated suggests that the movement has fallen short of expectations.⁸⁹ However, the Vihāra movement has also expanded to include new directions. For instance, although the official goals of the Vihāra initially stated a concern for “dealing with life (*inochi* いのち) in society,” this was eventually revised to reflect a broader concern that went beyond the life and death context of the hospice by “dealing with suffering (*kunō* 苦悩) in society.”⁹⁰ According to a twenty-year review of the Vihāra movement within the Honganji sect, the first two decades of the Vihāra movement can be divided into three periods: the creation of Vihāra (1986-1989); the development of regional Vihāra groups (1990-2000); and the reconsideration of Vihāra (2001-2008).⁹¹

The first period included the establishment of committees to study the potential of Vihāra activities and the establishment of regional Vihāra associations in the prefectures of Fukui,

⁸⁸ NHK Special, “Furusato inochi no hibi: Nagaoka Bihāra byōtō no ichinen,” May 9, 1993.

⁸⁹ There are, however, some indications that family members of patients are leaving Vihāra wards with a more positive view of Buddhism. Murase Masamitsu, “Kanwa kea byōtō ni okeru bukkyōsha no hyōka: Izoku chōsa kara.” *NBSFG Nenpō* 42 (November 2011): 1-13.

⁹⁰ Usui Atsuko, “Supirichuaru kea to shūkyō,” *Gendai shūkyō* (April 2002): 215.

⁹¹ Jōdo Shinshu Honganjiha Shakaibu (JSBS), “Bihāra no ayunda 20nen to kongo,” 5, accessed July 19, 2017, http://social.hongwanji.or.jp/files/vihala_20_soukatsu.pdf.

Osaka, Nara, and Tokyo. During the second period, the number of regional associations grew to more than thirty, and more than six hundred members undertook Vihāra training. These regional members offered their services at thirty-seven hospitals throughout Japan (including the hospice at Nagaoka Nishi Hospital) and at sixty-seven nursing homes.⁹² These services, however, rarely involved spiritual care. More often, these volunteer services included cutting grass and helping distribute meals to patients with the hope that these activities would help establish the trust necessary between Vihāra volunteers and hospice staff for more active involvement in caring for the elderly or patients' *kokoro*. By 2007 the number of Vihāra trainees in the Honganji sect had approached one thousand with over six thousand regional Vihāra members scattered across Japan. These volunteers continue to serve today at nursing homes and hospitals where they provide a listening ear to the elderly or patients, provide recreational events, and even fix wheelchairs.⁹³ Since the turn of the twenty-first century, however, the Vihāra movement has outgrown the hospice. For example, Vihāra activities now also include the distribution of food after natural disasters.⁹⁴ The broadening of Vihāra activities from the hospice setting can also be seen in the activities of Vihāra 21, a grassroots non-profit organization affiliated with the Ōtani branch of Jōdo Shinshū, which oversees housing and day services for the elderly and disabled in Osaka.⁹⁵

The expansion of the Vihāra movement to include so many disparate activities begs the question of what exactly the contemporary Vihāra movement represents. As one of its leaders, Taniyama Yōzō, has suggested, the contemporary Vihāra movement can be defined narrowly,

⁹² JSHS, "Bihāra 10kanen sōkatsusho," March 31, 1999, accessed July 19, 2017, http://social.hongwanji.or.jp/html/c11p8_04.html.

⁹³ JSHS, "Bihāra no ayunda 20nen," 41.

⁹⁴ Ibid., 18-31

⁹⁵ The "21" in their name refers to the 21st century, further attesting to their reformist vision. There is also a Vihāra Konomien nursing home in Osaka.

widely, or very widely. In its narrow definition, Vihāra refers to a Buddhist form of hospice care. In its wider definition, it includes all Buddhist activities and institutions that focus on aging, sickness, and death in the contexts of medical and social welfare. Finally, in its widest definition, Vihāra can include all Buddhist and non-Buddhist social activities that provide opportunities to reflect on “life” and “suffering” including disaster aid, education, and cultural programs.⁹⁶

Taniyama suggests that most people use the first two definitions but that in practice, most current Vihāra activities fall into the latter two.

1995 and the Mainstreaming of “Kokoro Care”

The broadening of the Vihāra movement beyond hospice care became especially pronounced after 1995, which was a major turning point for Japanese religion and society more broadly. On March 20, the members of a new religious group, Aum Shinrikyō オウム真理教, released poisonous sarin gas in the Japanese subways during the morning rush hour that claimed thirteen lives and injured over six thousand others. This incident terrorized Japan and fueled an increasingly suspicious view of religious groups.⁹⁷ Images of Aum adherents being brainwashed through consciousness altering practices with electrodes on their heads were widely broadcast in the media, and religious groups were depicted as playing anything but a “healthy” role in society. Moreover, 1995 was also a low point for Japanese religion in another important way. Two months prior to the Aum incident, a deadly earthquake hit the city of Kobe and its environs that claimed more than six thousand lives. In the immediate aftermath of the disaster, religious groups were largely unprepared to support the victims. As a newspaper editorial lamented:

⁹⁶ Taniyama Yōzō, “The Vihāra Movement: Buddhist Chaplaincy and Social Welfare in Japan,” in *Buddhist Care for the Dying and Bereaved*, Jonathan S. Watts, and Yoshiharu Tomatsu eds. (Boston: Wisdom Publications, 2012), 78-79.

⁹⁷ Baffelli and Reader, “Impact and Ramifications.”

Why is it that we do not see the priests there [at the site of the disaster] fulfilling their duty? Only a small portion of clergy and a few religious groups are listening to the silent cries of the disaster victims. They only hold funeral ceremonies and don't practice a religion that uses living words for people. The fact that there are few priests who will suffer alongside the people is enough to make one angry.⁹⁸

Spurred by such criticism, Japanese religious groups began to consider even more earnestly how they could play a larger role in social welfare in the years that followed.⁹⁹ When the 1998 Nonprofit Organization Law was passed, this opened the door for religious groups to more closely involve themselves with non-profit work. By the time the devastating earthquake and tsunami hit the Tohoku region on March 11, 2011, religious leaders seemed to have learned their lesson. On this occasion, religious groups were much better prepared as they immediately rushed to the sites of the disaster to support the survivors.¹⁰⁰

In addition to helping spur religious groups to seek ways to play a more decidedly “healthy” role in Japanese society more broadly, the events that took place in the year 1995 also opened new avenues for religious groups to participate in hospice care. One such avenue was a surge of public interest in the idea of caring for the “*kokoro*” (mind/heart) of those traumatized by personal tragedies, natural disasters, or impending death. As I have discussed elsewhere, *kokoro* care was originally associated with the holistic philosophy of hospice care that placed

⁹⁸ Mochizuki Masao, “Minshū to ‘dōku’ suru shūkyōsha ideyo,” *Mainichi Shimbun*, March 7, 1995.

⁹⁹ For examples of handwringing by religious figures see Nakamaki Hirochika and Tsushima Michihito, *Hanshin daishinsai to shūkyō* (Osaka: Tōhō Shuppan, 1996).

¹⁰⁰ Barbara Ambros, “My take: Japanese new religions’ role in disaster response,” *CNN Belief Blog*, March 22, 2011, accessed May 14, 2015, <http://religion.blogs.cnn.com/2011/03/22/my-take-japanese-new-religions-big-role-in-disaster-response/>; Keishin Inaba, “Religion’s Response to the Earthquake and Tsunami in Northeastern Japan,” *Dharma World*. (October/December, 2011), accessed June 5, 2013, http://www.rk-world.org/dharmaworld/dw_2011octdecreligionsresponse.aspx; Inaba Keishin, “Hisaichi shūkyōsha no katsudō to kōho shien no wa,” *Gendai shūkyō tokushū* (2012): 83-101; Levi McLaughlin, “Hard Lessons Learned: Tracking Changes in Media Presentations of Religion and Religious Aid Mobilization after the 1995 and 2011 Disasters in Japan,” *Asian Ethnology* 75, no. 1 (2016): 105-137.

value on caring for patients not only physically but also socially, emotionally, and spiritually.¹⁰¹ For example, a 1985 newspaper article on hospice care described a patient who bemoaned the lack of *kokoro* care offered by staff in a hospital—*kokoro* care that he only received from two other patients who were members of the religious groups Konkōkyō and Tenrikyō and could encourage him in his faith during his hospitalization.¹⁰² Likewise, a 1986 editorial describes the support for the establishment of Japan’s first Buddhist hospice in terms of its ability to provide “*kokoro* support” (*kokoro no sasae* 心の支え) and existing Christian hospices were referenced for their ability to provide “*kokoro* medicine” (*kokoro no iryō* 心の医療).¹⁰³ As these early occurrences show, *kokoro* care before 1995 was closely associated with care for terminally ill patients. While there was no consensus on who should provide *kokoro* care, these articles repeatedly called attention to the need for family members, doctors, nurses, religious professionals, and counselors to all address the *kokoro* of Japanese hospice patients.

In the wake of the 1995 Hanshin earthquake, however, use of the term blossomed in the media and came also to include broader psychological support for traumatized disaster victims. For example, in the *Asahi Shimbun* and the *Yomiuri Shimbun*, Japan’s two largest newspapers, the term “*kokoro* care” (*kokoro no kea* 心のケア) appeared only four times and nine times respectively in 1994, but surged to 216 and 202 times just a year later in 1995. In June of that year, the Japanese government also announced that one percent of all funds donated by private

¹⁰¹ Timothy Benedict, “Heart Care in Japan: Before and After the 1995 Hanshin Earthquake,” *Inochi no mirai* 1 (2016): 147-169. For example, the four earliest mentions of *kokoro* care in the *Asahi Shimbun* all arise in the context of care for the terminally ill.

¹⁰² *Asahi Shimbun*, “Makki kanja o dakishimeru,” May 28, 1985.

¹⁰³ *Asahi Shimbun*, “Bukkyō hosupisu no jitsugen o,” October 27, 1986.

and government sources toward disaster victims would be earmarked for the establishment of a “Kokoro Care Center.”¹⁰⁴

This mainstreaming of *kokoro* care after the Hanshin earthquake allowed for wider societal recognition of and demand for a type of care that went beyond biomedical approaches for suffering individuals who faced traumatic experiences related to disaster and death. As the idea of *kokoro* care became mainstream, the work of religious workers in hospice care was now also more likely to be distinguished from this broader term by using the label of “spiritual care.” While *kokoro* care became associated with psychological trauma more broadly, hospice literature emphasized a view that distinguished between the physical, social, psychological, and spiritual pain of patients. Terms like “spiritual care” helped transmit the nuances of existential and spiritual concerns that were more strongly identified with care for the terminally ill. As the next chapter will demonstrate, the introduction of the term “spiritual care” also marked a departure from the holistic view of care for the dying that *kokoro* care implied in favor of a more specialized notion of care for a patient’s “spirituality.”

By the late 1990s, spiritual care became even further entrenched in the discourse of hospice care through the establishment of several spiritual care training programs. For example, in 1998, the Clinical Pastoral Education and Research Center was formed to promote education and training in spiritual care. This was followed by several other training and professional organizations including the Japanese Spiritual Care Worker Association (2001), the Professional Association for Spiritual Care and Health (2005), the Japan Society for Spiritual Care (2007), and the Grief Care Research Center (2009). In 2012, the Japan Society for Spiritual Care set upon creating a national certification program that would establish the minimum criteria for

¹⁰⁴ Joshua Breslau, “Globalizing Disaster Trauma: Psychiatry, Science and Culture After the Kobe Earthquake,” *Ethos* 28 no. 2 (2000): 181.

chaplaincy training and allow for the recognition of spiritual care in Japan as a profession in its own right.¹⁰⁵ The late 1990s also marked the beginnings of a growth in academic and clinical discourse on the subject of “spirituality” and “spiritual care,” which will be examined in detail in the following chapter.

Conclusion

The historical and cultural context for Japanese religious engagement in medical welfare during the long twentieth century helps illuminate several themes that underlie the practice of spiritual care in the Japanese hospice today. First, it shows how Buddhist engagement in medical welfare, and social welfare more broadly continues to be motivated by a desire to play a “healthier” role in Japanese society. From Meiji era Buddhist reformers like Inoue Enryō to a contemporary Zen priest turned doctors like Tsushimoto Sōkun, over the course of the twentieth century, Buddhists have continued to decry their own lack of social engagement and to blame themselves for having “abandoned” their original mission of compassion and charity. Even while emphasizing their “failures,” at the same time, the leaders of the Buddhist hospice movement have also turned to pre-modern precedents such as the practice of *rinjū gyōgi* to underscore their historical expertise in care for the dying. As discussed above, the historical continuity between pre-modern and modern Buddhist medical welfare and between *rinjū gyōgi* and contemporary hospice care is largely imagined. Rather, modern notions of medical welfare are closely linked to ancillary developments that began in the Meiji period including the spread of Western medicine, urbanization, industrialization, and political policies that undercut the authority of local Buddhist

¹⁰⁵ For more on spiritual care training programs in Japan, see Kenta Kasai, “Introducing Chaplaincy to Japanese Society: A Religious Practice in Public Space,” *Journal of Religion in Japan* 5 (2016): 246-262. For a list and brief summary of spiritual care training programs, see also Appendix II.

temples. Nevertheless, Buddhist conceptions of their historical expertise in matters of health and care for the dying more broadly provide a powerful discursive tool to combat the modern stereotypes of Buddhism and has spurred a vocal minority of Buddhists to attempt to carve a vocational niche for themselves in the field of hospice care as well as in medical welfare activities more broadly.

Strangely enough, although the Vihāra movement is predicated on an effort to shed the “funerary” image of Buddhism, it also continues to promote Buddhist expertise in matters related to death. In this regard, one of the peculiarities of the Vihāra movement is the notable absence of a rationale for Buddhist engagement in hospice care based on the fact that they were already the undisputed authorities on *funerary* matters. In point of fact, many Buddhist chaplains I spoke with mentioned how patients and families would often consult them for advice on funeral arrangements. Funerals are an important site for bereavement care.¹⁰⁶ However, the Vihāra movement has largely avoided making a public case for their work on these grounds. Presumably, this is because the Vihāra movement portrays itself as an antidote to negative stereotypes that surround the priest’s vocation as a postmortem funerary and memorial ritual expert. On the other hand, hearkening back to *rinjū gyōgi* allows Buddhists to show that originally, they played an important role in care for the dying, and not just the already dead.

A second important theme in the history of medical welfare and hospice care in Japan is the role played by religious hospitals, and especially Christian hospitals, which helped establish and popularize hospice and spiritual care. Christian medical missionaries in late nineteenth and

¹⁰⁶ For example, at the 2015 Buddhist Nursing Vihāra Conference in Kanazawa, a Nichiren priest from Chiba reported on his efforts to provide bereavement care to family members at funerals. This included arriving about two hours earlier than normal in order to talk with family members and giving sheets of paper to attendees to write down memories of deceased during the wake. He also tried to pay greater attention to his tone when speaking and generally tried to make the funeral ceremony a more supportive space for bereaved family members to deal with their grief.

early twentieth century Japan played an active role in establishing medical institutions, some of which have grown to become prestigious hospitals today. Although Western medicine quickly became commonplace, Christian medical missionaries alongside native Japanese Christians put their efforts into establishing hospitals with a charitable mission until access to affordable medicine became ubiquitous in the 1960s. These hospitals then went on to become the primary sites for the introduction of hospice care in the 1980s. Although today, Christian hospices only represent eight percent of Japanese hospice wards, their pioneering role allowed them to play a disproportionate role in dictating the philosophy of hospice care, and especially in developing the models of spiritual care that will be discussed in the next chapter. For instance, in the early years of the Christian hospice movement, which is to say before 1995, the work of chaplains was (and in some places still is) referred to as “pastoral care.” One doctor who worked in hospice care during this period suggested that “back then in Japan, spiritual pain equaled religious pain.”¹⁰⁷ At Yodogawa Christian Hospital, an important model for hospice care in Japan, the chaplain’s office was originally known as the “Evangelization Department” (*dendōbu* 伝道部) before later adopting the less proselytizing appellation of “Chaplain’s Office” (*chaporenshitsu* チャプレン室). Christian doctors like Kashiwagi Tetsuo were also influential in framing the importance of hospice care in terms of the mottos espoused by their hospitals such as “whole person care.” In this way, the early institutional history of hospice care is key to understanding contemporary debates on how spiritual care should be defined and practiced. The prominent role played by Christian groups also helps explain why Buddhists labeled their work with the Buddhist term “Vihāra,” as they initially sought to establish their own original Buddhist model of hospice and spiritual care.

¹⁰⁷ Personal Interview, January 22, 2015.

More broadly, the discourse on and history of medical welfare and hospice care in Japan also points to the ways that religious groups in Japan now look to such engagement, both as a way to show their own “healthy” role in society and also as a way to live out their religious commitments of showing compassion and charity to those in need. This emphasis on “healthy” engagement then intensified after 1995, a year when two traumatic events—the Hanshin earthquake and Aum Shinrikyō’s sarin gas attack on the Tokyo subway—had seismic repercussions for religious groups in promoting extremely negative views of religion. As public interest in the practice of *kokoro* care for victims of trauma expanded, religious workers began forming spiritual care training programs that would allow them to enter and shape modern medical spaces in new ways.

Although the historical context of religious engagement in “healthy” activities during the twentieth century is key to understanding the development of hospice and spiritual care, in closing, several cautions are in order. First, it is important to note that although religious engagement in modern medical welfare is the most important context for understanding spiritual care, this is not to deny that religious groups did not participate in medical charity and healing activities before this. Japanese religious groups have always been interested in medicine and healing well before the growth of modern medical welfare activities. In pre-modern Japan, Buddhist priests often doubled as doctors and were the primary purveyors of Chinese medicine and healing rituals.¹⁰⁸ Early modern Japanese also flocked to temples and shrines to receive medicines and amulets that promised to heal a variety of illnesses.¹⁰⁹ The New Religions that arose in the late nineteenth and early twentieth century are also well known for attracting

¹⁰⁸ Pamela D. Winfield, “Religion and Healing in Pre-Modern Japan,” *Religion Compass* 6, no.11 (2012): 467-479.

¹⁰⁹ Duncan Ryūken Williams, *The Other Side of Zen: A Social History of Sōtō Zen Buddhism in Tokugawa Japan* (Princeton, NJ: Princeton University Press, 2005), esp. 86-116.

adherents through unique healing practices.¹¹⁰ Even today, a casual visitor to a Buddhist temple or Shinto shrine cannot fail to notice the many votive tablets (*ema*) with prayers for health or healing that are hung near Buddhas and deities that specialize in the medicinal arts.¹¹¹ These activities are all important for understanding the wider relationship between religion and medicine in Japan. However, what I do want to say is that in terms of the development of the hospice movement and spiritual care, the connection between these activities, which includes *rinju gyōgi*, and spiritual care in hospices today is largely imagined. Rather than serving as direct historical antecedents for Buddhist involvement in death and dying, instead they largely serve as legitimizing discourse. More important to understanding religious engagement with hospice work is the important role Meiji era Buddhist reformers, Christian medical missionaries, and historical events like the Hanshin earthquake or the Aum incident played in stimulating religious groups to articulate new rationales for engaging in medical welfare.

In addition, it is also important to note that while religious groups active today in hospice and spiritual care are vocal in the media, religious engagement in medicine still remains a very small field within Japan's larger religious landscape. For instance, the Nichiren-shū Vihāra Network was founded in 2001 and its website lists its various activities, regular reports, and upcoming lectures on spiritual care for the suffering and dying. It even sells hand towels (which are ubiquitous in Japanese gift giving) inscribed with their logo. But despite the estimated thirteen million Nichiren parishioners in Japan, only a total 7,801 homepage visits are recorded

¹¹⁰ Justin Stein, "The Japanese New Religious Practice of *jōrei* and *okiyome* in the Context of Asian Spiritual Healing Traditions," *Japanese Religions* 37, nos. 1-2 (2012): 115-141. Ioannis Gaitandis, "Spiritual Therapies in Japan," *Japanese Journal of Religious Studies* 39 no. 2 (2012): 353-85.

¹¹¹ Emiko Ohnuki-Tierney, "Health Care in Contemporary Japanese Religions," in *Healing and Restoring: Health and Medicine in the World's Religious Traditions*, ed. Lawrence E. Sullivan, 59-87 (New York: Macmillan, 1989).

on their website.¹¹² This suggests that there is a danger in overstating the actual interest that religious groups have in actualizing programs of care for the dying at a broader level. For instance, as Levi McLaughlin has noted in his study of interfaith chaplains in the field of disaster relief, the Japanese media has increasingly sought to valorize the work of religious groups in psychotherapeutic activities. These depictions are often “curated” and can even serve to marginalize “religious actors who do not fit a sanitized discourse deemed acceptable for public consumption.”¹¹³ In other words, although the work of religious groups in care for the dying or other medical and psychotherapeutic activities is often highlighted in the media, by scholars of religion, and in the websites and publications of religious groups themselves, it is important to bear in mind that these activities do not reflect the interests of all Japanese religious groups.

Despite these cautions, the alacrity with which the Japanese media and academic establishment have recently embraced the vision of religious groups caring for the dying is remarkable to see. A mere two decades ago, in the aftermath of the Hanshin earthquake and Aum incident, the public image of religious groups was at an all time low. However, as changing perceptions in national polls and surveys show, the memories of Aum are fading and the public image of religion is aiming for a “healthy” makeover. This vision was captured nicely on August 25, 2016, in a primetime documentary on the work of Japanese hospital chaplains that aired on Japan’s national television network (NHK). In the opening segment, the announcer’s voice overlays a video clip of a dying woman with her hands clasped together while a chaplain sat by her side. “A terminally ill woman. After death, where will she go? In order to remove anxiety about death, there are specially trained religious professionals. Right now, throughout hospitals

¹¹² Accessed December, 2017, <http://www.nvn.cc/>. In October 2015, the counter recorded just over 6,500 visits. This suggests that the website averages about one thousand visits (not unique visitors) a year. This includes perhaps a dozen of my own visits to the website.

¹¹³ McLaughlin, “Hard Lessons Learned,” 128.

and care facilities in Japan, medicine and religion are working together to achieve peaceful deaths.”¹¹⁴

¹¹⁴ NHK, “‘Odayaka na shi’ o mukaetai: Iryō to shūkyō aratana kokoromi,” *Kurōzuappu gendai* No. 3853, August 25, 2016.

Chapter Three

Talking in Circles:

Defining Spirituality for the Japanese Hospice

The theoretical and practical problem confronting the clinicians was to know whether it would be possible to introduce into a spatially legible and conceptually coherent representation that element in the disease that belongs to a visible symptomatology and that which belongs to a verbal analysis. The problem was revealed in a technical difficulty that was very revealing of the demands of clinical thinking: the picture.

-Michel Foucault¹

In late November 2014, I arrived in Beppu, a well-known hot spring resort on the eastern coast of Kyūshū, for a three-day weekend. But I was not there to soak in the sulfuric baths.

Instead, I joined more than three thousand participants in an annual conference hosted by the Japanese Association for Clinical Research on Death and Dying (*Nihon shi no rinshō kenkyūkai* 日本死の臨床研究会). The attendees were hospice workers or aspiring hospice workers and included doctors, nurses, social workers, chaplains, scholars, students, and volunteers. Who knew that care for the dying had become such an industry?

I had assumed that the conference would primarily feature presentations by doctors on clinical topics like the sedative benefits of fentanyl over morphine. However, as I perused the thick conference book, I was pleasantly surprised to see a number of lectures on the subject of spiritual care. One presentation in particular caught my attention. The presenter was Yamazaki Fumio, a well-known palliative care physician and author of the bestselling book, *Dying in a Japanese Hospital* (*Byōin de shinu to iu koto*, pub. 1990)—the book that helped fan the flames of the Japanese hospice movement by highlighting the poor quality care for the dying in Japanese

¹ Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (New York: Vintage Books, 1994), 112.

hospitals. The title of his talk was: “Spiritual Pain and Care: Defining Spirituality for a Better Understanding.” It was to be held in one of the medium-sized auditoriums with seating for 160 people. I made sure to go a little early in order to get a seat. When I arrived, I was surprised to see a long line already snaking around the auditorium as participants waited for the doors to open. I barely managed to squeeze in before organizers began turning people away. The room was packed. People stood and sat along the walls, in the aisles, and on the stairs. The standing area in the back of the room resembled a rush hour train in Tokyo. I finally managed to find a little space on the far side of the hall where I could peer at the podium with just enough room to scribble notes—if I tucked my elbows in tightly. Part of the abstract for the presentation read as follows:

Nobody disputes that physical pain arises because there is a body; psychological pain arises because there is a psyche; and social pain arises because there is a society. If this is so, shouldn't there be something that gives rise to spiritual pain? If we look for correspondences between physical pain, psychological pain, social pain, and spiritual pain, we should be able to say that spiritual pain arises because people have a spirituality. So then, the obvious question emerges: what is spirituality?²

As the press of hospice workers around me attested, it was a vexing question.

This chapter will demonstrate how questions of how to define spirituality in Japan are deeply imbricated in the clinical practice of spiritual care for the dying. How is spirituality related to religion? How is spiritual care different than psychological care? Do all patients have a “spiritual” dimension? The previous chapter focused on the institutional roles religious groups played in establishing medical services and hospice care on the ground, as well as how they mobilized a discourse on historical precedents of medical welfare to advance a vision of “healthy religion” that culminated in the hospice care movement. This chapter will shift our attention to

² Yamazaki Fumio, “Supirichuaru pein to kea: Sono yori yoki rikai no tame ni supirichuaru pein o teigi suru,” *Shi no rinshō* 37, no. 2 (2014): 208.

the background and definition of the operative concept in practice of spiritual care—the patient’s “spirituality”—and how these issues are addressed by prominent hospice practitioners and scholars who have theorized on and published their understandings of what makes Japanese spiritual care “spiritual.”

Ultimately, I argue that controversy over how to define the English loan word “spirituality” スピリチュアリティ in the Japanese context shows how the term works as a floating signifier that allows different stakeholders in the hospice movement to maintain or contest the acceptable parameters of religious care for dying patients. In addition, I show how the interpretation (and reinterpretation) of “spiritual care” and the concepts that undergird it cross-culturally has yielded divergent understandings of what spirituality means, and made the Japanese hospice one of the key spaces where philosophical questions on the nature of personhood are being produced and debated. In short, these attempts to apply “spirituality” in Japanese hospice care reveal a process by which conceptualizations of spirituality are being “invented” in the Japanese hospice. By invoking the “invention” of spirituality, I am consciously drawing on Jason Ānanda Josephson’s seminal work: “The Invention of Religion in Japan.” As Josephson argues, the provenance of “religion” (*shukyō* 宗教) as a concept in Japan was quite recent. The term gained purchase in Japan as a “boundary-drawing exercise” that sought to demarcate religion from other categories such as the secular, science, or superstition. It was not an unveiling of a universal academic or ethnographic category.³ While there are important differences, I suggest the “invention” of spirituality in the Japanese hospice is not unlike this process of indigenizing a modern Western concept into the Japanese lexicon to help negotiate the lines between the religious and the secular.

³ *The Invention of Religion in Japan* (Chicago: University of Chicago Press, 2012), 2-3.

As I lay out the parameters of these definitional debates and their implications for the practice of spiritual care, one of the themes this chapter will highlight is that Yamazaki's question about the nature of spirituality is part of a global conversation. In Japan, this conversation was first begun by the Buddhist author D.T. Suzuki, who introduced the term "spirituality" and its initial Japanese translation as *reisei* 霊性, in the 1940s. Later, the Japanese transliteration of the word "spiritual," or *supirichuaru*, began to appear in print during the 1980s as part of a growing genre of New Age literature, and then finally blossomed during the expansion of hospice care after the 1990s when definitions of spirituality were illustrated through various Venn diagrams for clinical instruction. In tracing this genealogy, I will show how Western and Japanese understandings of spirituality are being transposed and re-appropriated across cultural boundaries.

Another key theme running through this chapter is that the term "spirituality" is best understood in Japan as a label that helps negotiate movable boundaries. In short, spirituality in Japan is often invoked in a way similar to its use in other, English-speaking countries: it typically marks itself as something in, parallel to, or in contradistinction with religion.⁴ For Japanese religious professionals in particular, the language of *supirichuariti* provides a sufficiently neutral label for socializing their presence and justifying their work in hospice spaces.

Finally, the third theme of this chapter concerns the process by which spirituality in the Japanese hospice has been reified and medicalized into a dimension of *being*. This concept of the spiritual as a natural dimension of all persons, along with identifying the spirit as a locus of pain,

⁴ John Lardas Modern, *Secularism in Antebellum America: With Reference to Ghosts, Protestant Subcultures, Machines, and Their Metaphors: Featuring Discussions of Mass Media, Moby-Dick, Spirituality, Phrenology, Anthropology, Sing Sing State Penitentiary, and Sex with the New Motive Power* (Chicago: University of Chicago Press, 2011), 123.

is certainly not unique to Japan.⁵ However, the extent to which this reification has been extended—especially through the extensive use of diagrams in Japanese medical and academic texts that address the topic of spiritual care—is quite remarkable. As Foucault reminds us, the clinical gaze seeks to localize illness and is inherently ocular.⁶ In the end I suggest that efforts to delineate a “spiritual dimension” in patients that can serve as the locus of spiritual pain has at times also ironically undermined the central tenet of hospice care, which is to treat patients as a *whole* person.

The chapter is organized into three broad sections and each section will not correlate to, but rather include to various degrees, the three themes outlined above. The first section will discuss the genealogy and cultural context for the term “spirituality” in Japan. After detailing how “spirituality” entered the Japanese lexicon, it will then briefly turn to academic scholarship on the concept of spirituality in Western contexts to make some critical observations on the utility of this term as an academic category of analysis. The second section will then introduce how spirituality has become implemented in global clinical discourse and especially in hospice care. It will also outline some of the ways in which spiritual care is susceptible to reification and has been shaped by legal pressures. Finally, the third section will attend to the central concern of this chapter—how the concepts of spirituality, spiritual care, and spiritual pain have been appropriated by leaders of the hospice care movement in Japan.

The Invention of Japanese Spirituality

This first section traces the genealogy of the term “spiritual” (*supirichuaru*) and its

⁵ American chaplaincy organizations also issued a consensus paper that describes the “spirit” as “the natural dimension of all persons.” Larry Vandecreek and Laurel Burton eds., “Professional Chaplaincy: Its Role and Importance in Healthcare,” *Journal of Pastoral Care and Counseling* 55, no. 1 (2001): 81.

⁶ Foucault, *The Birth of the Clinic*, 3, 88.

cognates in Japan to show how the term functions to negotiate the boundaries between religion and the secular. It will first consider the role played by the Buddhist thinker D.T. Suzuki (1870-1966) who tried to redefine religion for his modern Japanese audience and the growth of the “spiritual world” movement that began in the 1970s. It will then turn to examine English language scholarship on the concept of spirituality to show how the term “spiritual” outside of Japan largely functions as a floating signifier that marks the boundaries between a diverse range of religious and non-religious beliefs and practices. This broader view helps us see how spirituality is being “invented” in Japan as a malleable concept that serves the purposes of both religious and secular stakeholders in the hospice care movement.

D.T. Suzuki and Japanese Reisei

Long before the advent of modern hospice care in Japan, one of the first authors who attempted to define Japanese spirituality was Suzuki Daisetsu— better known to his English readers as D.T. Suzuki. Suzuki’s 1944 work, *Japanese Spirituality (Nihonteki reisei 日本の靈性)*, showcases his understanding of Japanese spirituality through a sweeping look at Japan’s religious history.⁷ Suzuki’s first articulation of this concept is not only important because he was one of the first to participate in this conversation on the “spiritual” in Japan, but because his work also represents an important attempt to conceptualize what we might call a “non-religious

⁷ This work was followed by three additional works that dealt with the topic of “spirituality”: *Reisei-teki Nihon no kensetsu (The Building of Spiritual Japan)*, 1946; *Nihonteki reisei-teki jikaku (The Awakening of Spiritual Japan)*, 1946; and *Nihon no reisei-ka (The Spiritualization of Japan)*, 1947. Although Suzuki privately wrote in 1947 that he felt the English term “spiritual” to be an inadequate rendering of *reisei*, I have followed Norman Waddell in translating *reisei* as “spirituality.” As Waddell notes, *reisei* for Suzuki is generally synonymous with “religious consciousness.” However, Suzuki purposely avoids using the word “religion” (*shūkyō*) for reasons detailed below. *Suzuki Daisetsu zennshū*, vol. 29 (Tokyo: Iwanami, 1970), 409; Suzuki Daisetz, *Japanese Spirituality*, trans. Norman Waddell (Tokyo: Yushodo, 1972), 24.

religion” in Japan.⁸

Suzuki begins by acknowledging that the word *reisei* 靈性 or “spirituality” may not be as familiar to his modern readers as the more common word *seishin* 精神 or “mind and spirit.” In order to clear up their differences, he first defines *seishin* as that which pertains to the *kokoro* 心 (mind/heart), *tamashii* 魂 (spirit/soul); or *chūkaku* 中核 (nucleus) of things. However, Suzuki warns that neither *kokoro* nor *tamashii* are exact synonyms of *seishin*. He notes that *tamashii* feels concrete-- like a round object that “might roll before your eyes.”⁹ In contrast, *seishin* has an abstract quality and is “vast.” Suzuki also notes that *seishin* presupposes a dualism that places its own ephemeral nature in opposition with material substances or forms. It was important for Suzuki to show the implicit dualism in the word *seishin*, since this insight leads directly into his understanding of the nature of *reisei*:

In a view that sees *seishin* (or *kokoro*) in opposition to substance, *seishin* cannot be contained within substance, and substance cannot be contained within *seishin*. There is something more that must be seen at the innermost depths of *seishin* and substance. As long as two things oppose each other, contradiction, rivalry, mutual suppression, and annihilation will be unavoidable. Where this occurs man’s existence cannot continue. What is needed is something that somehow sees that the two are really not two, but one, and that the one is, as it is, two. It is *reisei* that does this. For the heretofore dualistic world to cease its rivalries and become conciliatory and fraternal, and for mutual interpenetration and self-identity to prevail, one must await the awakening of man’s *reisei*.¹⁰

⁸ By a “non-religious religion,” I refer to a view that seeks to discard traditional religious practices and institutions as authoritarian and narrow-minded, in favor of a “true religion” that is more free and open-minded. Dietrich Bonhoeffer’s (1906-1945) also invokes a similar term, “religionless Christianity” (*Religionsloses Christentum*), which Kelly and Nelson describe as “a new ‘form’ of Christianity in which people of a genuine Christian faith would live in a more open, constructive relationship with the world... freed from its [religions’] more Westernized, self-serving constrictions and emphasis on inward piety and empty rituals.” This view is also manifested in the now common refrain, “spiritual but not religious.” Geoffrey B. Kelly and F. Burton Nelson, *A Testament to Freedom: The Essential Writings of Dietrich Bonhoeffer* (New York: HarperSanFrancisco, 1995), 547-548.

⁹ Suzuki *Daisetsu zennshū*, vol. 8 (Tokyo: Iwanami, 1968), 18. In describing the *tamashii* as round, Suzuki is likely alluding to the etymological associations between *tamashii* and *tama* (玉), which refers to a gem or round object.

¹⁰ Suzuki, *Japanese Spirituality*, 14-15.

In this passage we can taste the Buddhist flavor of Suzuki's call to move beyond a dualism that is predicated on discrimination between *seishin* and substance. It also looks at first glance as if Suzuki is advocating a view of *reisei* in Buddhist terms. Suzuki, however, is clear that *reisei* is something far superior to religion:

Reisei might be called religious consciousness, except that misconceptions tend to arise when we speak of religion. Japanese do not seem to have a very profound understanding when it comes to religion. They think of it as another name for superstition, or that religious belief can support something, anything, which has nothing to do with religion. Consequently, I do not speak of religious consciousness, but *reisei*. Yet basically, to the degree one does not raise a consciousness toward religion it is not understandable... religion is understood only with the awakening of *reisei*. I do not mean to suggest *reisei* possesses an ability to perform some special activity, but that its *hataraki*, or "operation," is different from that of *seishin*.¹¹

In this second passage Suzuki argues that the term *reisei* helps avoid the pitfalls of Japan's shallow understanding of religion. Although *reisei* is practically synonymous with religious consciousness, *reisei* denotes something far deeper, like an inner faculty, which must be awakened before religious consciousness is even possible. Later, it becomes even clearer that what he really means by religious consciousness is the fundamental insight of Buddhism.

First, you may be just a little bit unfamiliar with the word *reisei*. I would like to use it with the following meaning. In all humans, something called consciousness (*ishiki* 意識 Skt. *mano-vijñāna*)—well, we could also call it a *kokoro*—exists. This can be divided into two parts; I will call one "intellect" (*chisei* 知性) and the other "spiritual" (*reisei*). In Buddhism, I think it is safe to say that the intellect corresponds to the combination of consciousness (*ishiki*) and the "seventh consciousness" (*manashiki* 末那識 Skt. *mana-vijñāna*) and the spiritual corresponds to *hannya* (般若 Skt. *prajñā*).¹² However, when you say *hannya*, it is translated as "wisdom" (*chie* 知恵), and the intellectual part becomes stronger in its meaning. From the beginning, *hannya* has intellectual and intuitive aspects, but it should be properly called spiritual intuition (*reiseiteki chokkaku*

¹¹ Ibid., 15.

¹² In Yogācāra Buddhism, *mano-vijñāna* and *mana-vijñāna* represent the sixth and seventh of eight types of consciousness. *Prajñā*, meaning wisdom, refers to the Buddha wisdom that realizes no-self, emptiness, and brings about enlightenment. Here, Suzuki is trying to contrast the ineffable insights of *prajñā* with the more common noetic qualities associated with *mano-vijñāna* and *mana-vijñāna*.

靈性的直覺) and its essence is not intellectual.¹³

In this third passage, Suzuki ultimately presents *reisei* as Buddhist “wisdom” (Jp. *Hannya*, Skt. *Prajñā*), or a faculty of religious insight that lies at the core of Buddhism.¹⁴ He then goes on to explain that while *reisei* does not arise out of the intellect, the intellect can only arise out of *reisei*. He also notes that while the intellect can be caught in dualistic thinking, *reisei* helps to counter that tendency by its indiscriminating nature. Furthermore, although he speaks of a Japanese *reisei*, he suggests that it is also universal, although manifested differently across cultures.

Ultimately, Suzuki sees *reisei* as a fresh term that avoids the baggage that comes with the Japanese “shallow” understanding of religion. But the spirituality that Suzuki describes is not one that is directly opposed to religion, but rather, deeper than religion. Although Suzuki allows that spirituality might be manifested differently around the world, in the case of Japan, he states that the fundamental insights of Buddhism are the true manifestations of Japanese spirituality. Even though he suggests that spirituality is not an exact synonym with religious consciousness, he believes that they are very much connected. Suzuki also views spirituality as something that resides within a person, which becomes “awakened” (*kakusei* 覚醒) and has an “operation” (*hataraki* 働き) that leads to Buddhist insight. Furthermore, Suzuki views *reisei* as an integral part of human nature, or as a human faculty. Although he framed it in his particular understanding of Buddhism, Suzuki thus became one of the first Japanese to describe spirituality as something that is different from religion, resides deep in every person, and becomes

¹³ Suzuki *Daisetsu zenshū*, vol. 8, 250.

¹⁴ By comparison, Suzuki discounts Shinto as being too intellectual and lacking the spiritual intuition found in Buddhism. *Ibid.*, 264.

“awakened.”¹⁵

The significance of Suzuki’s introduction of the term *reisei* in Japan goes beyond his pioneering role in conceptualizing a Japanese spirituality that is both different from but also predicated on a kind of religious consciousness. For example, one former Japanese hospital chaplain I interviewed in 2013 related how Suzuki’s work also had an indirect effect on contemporary models of spiritual care. When this chaplain received his clinical pastoral education (CPE) training in California, he noticed that much of what he was learning felt vaguely familiar. In fact, at times, it even felt Buddhist. He later realized that much of the CPE curriculum was heavily influenced by leading figures in humanistic psychology such as Eric Fromm and Carl Jung— both of whom had close relationships with Suzuki and were influenced by work.¹⁶ For example, ideas about helping patients with “self-realization” were reminiscent to this chaplain of the Zen Buddhist emphasis on “awakening the true self.” This chaplain is now in the peculiar situation where he teaches students in Japan about spiritual care, based on training he received in the United States, which was influenced by Swiss psychotherapists such as Carl Jung, who in turn appropriated elements of Suzuki’s brand of Japanese Zen Buddhism. In this way, the discourse on spirituality in Japan has from the very beginning been a global conversation where ideas and practices related to spirituality have moved back and forth across cultural borders.¹⁷

¹⁵ For more on Suzuki’s understanding of *reisei*, see Tsukiyama Shūdō, “Suzuki Daisetsu no reisei jikaku no ichi kōsatsu, *Shūkyō kenkyū* 84, no. 2 (2010): 175-199.

¹⁶ Jung wrote the foreword to Suzuki’s *Introduction to Zen Buddhism* (1939). Fromm, Suzuki and Richard De Martino also co-authored a book titled *Zen and Psychoanalysis* (1970).

¹⁷ For example, mindfulness therapies and *reiki* therapies based on Asian religious traditions have also traveled dialectically across the North Pacific and gained much popularity in Western medical settings. See Justin B. Stein, “Hawayo Takata and the Circulatory Development of Reiki in the Twentieth Century North Pacific” (PhD Diss., University of Toronto, 2017).

“Spiritual World” Movement

For several decades after Suzuki, the term *reisei* attracted little attention.¹⁸ This finally changed when the “spiritual world” (*seishin sekai* 精神世界) or “new spirituality movement” (*shin reisei undo* 新靈性運動) began to unfold in the 1970s and through the 1980s. Shimazono Susumu has traced the beginnings of this movement to when Japanese bookstores began offering a section on the “spiritual world.”¹⁹ This new genre of books bore a marked similarity to what has been described as “New Age” literature in the West, and included such themes as alterations of mind and spirit, search for the self, self-realization, self-transcendence, and self-liberation.²⁰ As the repeated use of the word “self” suggests, a further characteristic of the “spiritual world” genre was an emphasis on individual spiritual growth rather than group participation in organized religious activities. Shimazono Susumu points out that this interest in spirituality represented a third path for many members of Japan’s postmodern generation who sought alternatives to religion and modern rationalism.²¹

But it was not until the late 1980s that the term *supirichuaru*, a transliteration of the English word “spiritual,” rather than *reisei*, began to attract concentrated attention. As Horie Norichika notes, in English, “spiritual” is closely tied to its root, “spirit;” but in Japanese, *supirichuaru* could be freed from the supernatural associations of *reisei*.²² The eventual eclipse of *reisei* by *supirichuaru* became even more pronounced in the wake of the public backlash

¹⁸ It was, however, occasionally used in Christian circles as a translation for the English word “spiritual” in theological texts. Horie Norichika, “Reisei kara supirichuariti e,” *Kokusai shūkyō kenkyūjo nyūsuletā* 38 (April 2003): 14-22.

¹⁹ Shimazono, *Supirichuariti no kōryū*, 5. See also *Seishin shakai no yukue: Shūkyō, kindai, reisei* (Tokyo: Akiyama Shoten, 2007); Shimazono, *From Salvation to Spirituality*; and Shimazono and Graf, “The Rise of the New Spirituality.”

²⁰ Shimazono and Graf, “The Rise of the New Spirituality,” 460.

²¹ Shimazono, *Seishin shakai*, 4.

²² Horie Norichika, “Spirituality and the Spiritual in Japan.”

against religion after the Aum incident in 1995. The widely broadcast images of Aum adherents being brainwashed through religious consciousness altering practices instilled a deep suspicion of religious groups for many Japanese. As a result, authors and leaders in the genre of spiritual world literature emphasized less threatening practices such as achieving personal wellbeing through mindfulness practices. By transliterating “spiritual” in *katakana* syllabary, the spiritual world genre also sought to play down the supernatural nuances expressed by the Chinese characters for *reisei*. This made it more attractive—or at the very least, palatable—for public consumption.

This strategy can be observed in the works of Ehara Hiroyuki 江原博之 (1964-), a well-known psychic author, TV personality, and self-described “spiritual counselor.” Ehara’s first two books, “Promoting ‘Spiritual Learning’ for Yourself” (1994) and “Psychic Bible” (1995) both used the word *rei* 霊 or “spirit” in their titles.²³ But starting in 2001, Ehara vaulted into the publishing stratosphere by writing more than forty books whose titles all contained the word *supirichuaru*. Ehara himself emphasized the distinction between the paranormal and *supirichuaru* by describing the content of his books as “spiritual” and not “spiritualism (*supirichuarisumu* スピリチュアリズム),” since the latter term had been used since the early twentieth century by occult groups as well as by Japanese New Religions.²⁴ To make this point even clearer, Ehara employed a healthy-sounding metaphor: “spiritualism” is like rice, while the

²³ Ehara Hiroyuki, *Jibun no tame no “reigaku” no susume: Ningen o migaki, reisei o migaku* (Tokyo: Hato Shuppan, 1994); *Shinrei baiburu* (Tokyo: Magajinhausu, 1995).

²⁴ Helen Hardacre, “Asano Wasaburo and Japanese Spiritualism in Early Twentieth-Century Japan,” in *Japan’s Competing Modernities: Issues in Culture and Democracy 1900-1930*, ed. Sharon A. Minichiello, 133-53 (Honolulu: University of Hawai’i Press, 1998). Yoshinaga Shinichi, “Kindai Nihon ni okeru shinchigaku shisō no rekishi,” *Shūkyō kenkyū* 84, no. 2 (2010): 375-397.

“spiritual” is like rice porridge and can be more easily digested by beginners.²⁵

This healthy metaphor is no accident. Although the word *supirichuaru* in contemporary Japan is often associated with psychic figures like Ehara, it is also closely linked to the rise of self-help groups and a therapy culture that began in both Japan and the West during the 1980s along with growing attention to the fields of transpersonal psychology, death education, holistic medicine, and hospice care.²⁶ However, this so-called “spiritual boom” that Shimazono and other religious scholars have documented requires some qualification since this “boom” did not necessarily reverberate in all sectors of Japanese society. In fact, surveys show that many Japanese outside of the spiritual world movement or the field of hospice care were hardly familiar with the meaning of *supirichuariti*. In a 2006 survey, for instance, only slightly more than twenty percent of Japanese were familiar with the term. Recognition improved among college students of whom forty-five percent recognized the term. In the health profession, recognition improved to almost fifty-five percent of regular nurses and eighty-five percent of palliative care nurses.²⁷ These numbers suggest that despite growing media coverage of this topic, it remains very much an insider term amongst medical and especially hospice workers who are socialized into it through their medical education and training. The high percentage of palliative care nurses who expressed familiarity with the term also indicates its particularly close association with end of life care. There is good reason for this. The discourse on spirituality in Japan remains tightly intertwined with the hospice movement—primarily due to the theorizing of spiritual pain as a key symptom that patients exhibit at the end of life. However, before

²⁵ Quoted in Andō Yasunori, “‘Supirichuariti’ gainen no saikō: Supirichuariti wa reiteki sekaikan o zentei to suruka?” *Shiseigaku nenpō* 4 (March 2008): 14.

²⁶ Shimazono, *Seishin shakai*, 243-53.

²⁷ Koyabu Tomoko et al., “Supirichuariti no ninchi to umu to kotoba no imēji: Kanwa kea byōtō no kangoshi, ippan byōtō no kangoshi, ippan no hito, daigakusei no tokuchō,” *Kawasaki iryō fukushi gakkai shi* 19, no.1 (2009): 59-71.

discussing how the concept of spirituality has been adopted in Japanese clinical settings, a few critical notes on spirituality as a scholarly category is in order.

English Language Scholarship on Spirituality

Here I will momentarily step back from Japan to critically examine spirituality as a scholarly concept in English-language scholarship. This wider context is important for two reasons. First, it suggests new avenues to critically examine the concept of spirituality and practice of spiritual care in Japan, and second, it shows how the development of hospice care and spiritual care in Japan has transpired as part of a much larger international conversation.

Although a full investigation of spirituality as a concept would require a separate dissertation (or two), here I will briefly pay attention to questions of how spirituality is defined, its relationship to religion, and its associations with individualism. A key finding, chiefly of English language scholarship, is how the term spirituality primarily serves to mark boundaries when faced with a diverse range of religious and non-religious beliefs and practices.

The first major difficulty many scholars of religion have with the term “spirituality” is definitional.²⁸ Courtney Bender, for example, likens her research on American spirituality to “shoveling fog.”²⁹ Similarly, a website on spirituality curated by John Lardas Modern states: “Spirituality abounds, even as it is unclear what it is. Whatever it is, it seems hard to capture. Spirituality takes hold beneath the skin and permeates below the radar of statistical surveys. It resists classification even as it classifies its evaluators and its believers as subjects of its sway.”³⁰

²⁸ For instance, a study of the term “spirituality” in the Denmark yielded six different meanings. Peter la Cour, Nadja Hørdam Ausker, and Niels Christian Hvidt, “Six Understandings of the Word ‘Spirituality’ in a Secular Country,” *Archive for the Psychology of Religion* 34 (2012): 63-81.

²⁹ Bender, *The New Metaphysicals*, 182.

³⁰ Frequencies: A Collaborative Genealogy of Spirituality Website, “Project Statement,” accessed April 2,

So what do scholars make of spirituality if it is foggy and below the radar? Can it still be studied?

Preliminary evidence suggests the answer is yes. Bender for instance points out that although spirituality is notoriously vague as a category of analysis, it nonetheless can be studied through the concrete practices of spiritual seekers in a wide variety of religious and secular contexts.³¹ These practices are not entirely new. Rather, as Leigh Eric Schmidt shows, they can be traced back to nineteenth-century America and the formation of a liberal religious progressivism that sought a religious world larger than its Protestant inheritance.³² Modern also shows that, understood in this way, spirituality can be thought of as a new rhetorical device, or, a grammar, that expresses individual intentions within, against, or alongside religious institutions.³³ In other words, spirituality is not really an ontological *thing* but rather describes a *way* of going about things. As these scholars suggest, if spirituality is to be studied and invoked as a category, it must be firmly embedded within the context of the historical discourses and institutional structures through which it is being produced.

The conceptualization of spirituality also bears close resemblance to the forming of another modern concept that is notoriously difficult to define—religion. As scholars of religion are keen to point out, religion as an object of academic study is a distinctly modern discipline.³⁴ This is especially true in the case of Japan where the use of “religion” (*shūkyō* 宗教) as a term in public circles did not gain traction until the very end of the nineteenth century.³⁵ One key to

2016, <http://frequencies.ssrc.org/project-statement/>.

³¹ Bender, *The New Metaphysicals*, 182.

³² Leigh Eric Schmidt, *Restless Souls*, 5.

³³ Modern, *Secularism in Antebellum America*, 123.

³⁴ Brent Nongbri, *Before Religion: A History of a Modern Concept* (New Haven: Yale University Press, 2013).

³⁵ Josephson, *The Invention of Religion in Japan*.

understanding how religion as a modern academic concept was formed is its relationship with secularism. As Talal Asad notes,

I would urge that “religion” is a modern concept not because it is reified but because it has been linked to its Siamese twin “secularism.” Religion has been part of the restructuration of practical times and spaces, a rearticulation of practical knowledges and powers, of subjective behaviors, sensibilities, needs, and expectations in modernity. But that applies equally to secularism, whose function has been to try to guide that rearticulation and to define “religions” in the plural as a species of (nonrational) belief.³⁶

Asad could just as well be speaking about the formation of the concept of spirituality. In other words, just as the rearticulation of “religion” as a modern concept takes place through the discourse of secularism, the growing discourse on spirituality is similarly tied to the discursive spaces between the oppositional poles of religion and secularism. In the United States for example, this can be seen in the well-worn descriptor, “spiritual but not religious.” As Robert Wuthnow points out, at its core, new individualized spiritual practices are a way of “retrieving the neglected middle in our understandings of religion.”³⁷ Spiritual seekers are found on a spectrum that extends between organized religious communities and their secular fringes. The concept of spirituality thus emerges between these co-constitutive poles, serving as a “grammar” that helps to locate individual subjectivities on this spectrum. From this perspective, spirituality is not to be mistaken for the lay of the land. The reason it is hard to map is because there is no firm territory to map. Rather, as noted previously, spirituality emerges as the discursive shadow that helps to mark claims against, for, or alongside religion.

By studying spirituality as a type of discourse that seeks to draw boundaries between religion and the secular, recent English language scholarship on spirituality has also challenged

³⁶ Talal Asad, “Reading a Modern Classic: W. C. Smith’s ‘the Meaning and End of Religion’,” *History of Religions* 40, no.3 (2001): 221.

³⁷ Robert Wuthnow, *After Heaven: Spirituality in America Since the 1950s* (Berkeley: University of California Press, 1998), 16.

the way some scholars of religion still lapse into using the term “spirituality” as if the meaning of the term was self-evident.³⁸ As Jonathan Herman points out, despite a scholarly consensus that “spirituality” is best considered as an emic category of discourse rather than an etic category of analysis, religious studies journals and conferences remain rife with uncritical usage of “spirituality” as an etic term.³⁹ This shows how scholars are still at risk of reproducing the way spiritual seekers themselves articulate the characteristics of spirituality as forms of interior or private beliefs and practices that stand apart from organized or institutionalized religion—encapsulated once again in that familiar phrase, “spiritual but not religious.” The danger in reproducing this binary between spirituality and religion, however, is that such statements can sound smug. As Herman playfully points out, the dichotomy between religion and spirituality could easily be replicated with the male and female reproductive organs. Religions are demarcated from spirituality by their externality, overtness, hardness, preoccupation with size, and misuse of power. In contrast, spirituality is typified as internal, soft, preoccupied with depth, and vulnerable. In other words, when scholars of religion reproduce the characterizations of spirituality through the language of spiritual seekers themselves, their research is in constant danger of confusing scholarly classification with judgment.⁴⁰ Herman notes that definitions of spirituality ultimately project “modern, western, cosmopolitan, religiously liberal values” such as “individualism, interiority, privacy, and non-dogmatic progressivism.”⁴¹

A further problem with uncritical use of the term spirituality by scholars of religion is how it characterizes the “spiritual” as individualistic. This characterization can obscure the ways

³⁸ For more on the porous boundary making involved in the two concepts of religion and secular, see Nancy T. Ammerman, “Spiritual But Not Religious? Beyond Binary Choices in the Study of Religion,” *Journal for the Scientific Study of Religion* 52, no.2 (2013): 258-278.

³⁹ Herman, “The Spiritual Illusion,” 162-163.

⁴⁰ Craig Martin, *Capitalizing Religion*, 28

⁴¹ Herman, “The Spiritual Illusion,” 171.

individual beliefs and practices are socially constituted and also diminishes the potential for social critique.⁴² While spiritual practices may seem individual and choice driven on the surface, they are also closely tied to their social, historical, and cultural milieu. As Bender has persuasively shown, spiritual practices cannot be easily disentangled from the social life or history of the people who engage in them or the spaces where they are produced. This is not to deny that spiritual seekers articulate their beliefs and practices in individualistic terms. For example, in *Habits of the Heart*, Robert Bellah and other sociologists memorably introduced these eclectic and individualistic religious beliefs and practices that a woman called Shelia subscribed to in highly individual terms as “Sheliaism.”⁴³ But if individualistic tendencies are indeed one of the defining features of spirituality, there still remains the question of how “spirituality” might signify something substantially different than phenomena labeled as “individualized religion” or even “privatized experience.”⁴⁴

These insights from English-language scholarship on spirituality are pertinent to understanding the ways in which spirituality is being “invented” in Japan. Beginning with D.T. Suzuki’s explication of *reisei*, we see the beginnings of a modern effort to redefine religion in Japan. The “spiritual world” movement that began in the 1970s also showed an expanding public interest in looking beyond Japan’s traditional religious institutions and beliefs for personal growth and fulfillment. After the Aum sarin gas attacks of 1995, a negative image of religion and

⁴² Martin, *Capitalizing Religion*, 6. Matthew Wood, “The Nonformative Elements of Religious Life: Questioning the ‘Sociology of Spirituality’ Paradigm,” *Social Compass* 56, no.2 (2009): 237-248; Barbara Pesut et al., “Conceptualising Spirituality and Religion for Healthcare,” *Journal of Clinical Nursing* 17, (2008): 2803-2810.

⁴³ Robert Bellah et al., *Habits of the Heart: Individualism and Commitment in American Life* (Berkeley, University of California Press, 1985), 235.

⁴⁴ Heinz Streib and Ralph W. Hood eds., *Semantics and Psychology of Spirituality: A Cross-Cultural Analysis*, (Cham: Springer, 2016); Shimazono Susumu, “Supirichuariti no genzai to sono imi,” in *Iyashi o motomeru tamashii no kawaki: Supirichuariti to wa nanika*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku shuppankai, 2011), 102.

the paranormal overtones of *reisei* helped catapult the relatively unknown term “*supirichuaru*” into public discourse. In a climate of suspicion towards all things religious, popular psychics like Ehara Hiroyuki took advantage of this “spiritual” language, which he framed in “healthy” terms. These events all speak to the ways in which the “spiritual” served to mark out a territory that was seen as neither religious nor secular.

The more critical vein of global scholarship on the concept of spirituality can also help us see the ways scholars in Japan sometimes take the term “spiritual” for granted or even unwittingly celebrate it. For instance, Shimazono Susumu describes the efforts of Japanese Buddhists to become involved in activities like spiritual care as something that society views with “potential and hope,” and asks his non-religious readers to use the opportunity of learning about “spirituality” to rethink their understanding of themselves as “outside” religion.⁴⁵ Kashio Naoki, a scholar of religion at Keio University, also explains public interest in the topic of spirituality as connected to the “universal spiritual desires” of persons who unsuccessfully try to drown out their modern problems through technology during times of uncertainty.⁴⁶ Likewise, Hayashi Yoshihiro, a scholar of philosophy and religion, expresses his hope that spirituality will serve the members of Japanese society whose hearts have “lost their bearings.”⁴⁷ As these statements show, “spirituality” is sometimes invoked in Japanese scholarship in ways that essentialize and valorize it.

As the next section will demonstrate, the invention of spirituality as something positive

⁴⁵ *Gendai shūkyō to supirichuariti* (Tokyo: Kōbundō, 2012), 140, 7.

⁴⁶ “Supirichuariti to wa nani ka? Gendai bunka no reiseiteki shosō,” in *Bunka to reisei*, ed. Kashio Naoki (Tokyo: Keio Gijuku Daigaku Shuppan, 2012), 3. He has also published a book that is optimistically titled, “The Spiritual Revolution: The Potential of Contemporary Spiritual Culture and the Opening of Religion.” *Supirichuariti kakumei: Gendai reisei bunka to hirakareta shūkyō no kanōsei* (Tokyo: Shunjusha, 2010).

⁴⁷ *Toi to shite no supirichuariti: “Shūkyō naki jidai” ni seishi o kataru* (Kyoto: Kyoto Daigaku Gakujutsu Shuppankai, 2011), iii.

that is “deeper” and “healthier” than religion intensifies in clinical settings. Whereas this section highlighted the ways in which the language of spirituality is best seen as a grammar that helps draw lines between the religious and the secular and how characterizations of spirituality as “individualistic” obscures the ways in which it is entangled in social life, the next section will introduce how the concept of spirituality in clinical settings came to be defined and universalized in global medical literature as a dimension of *being*.

Spirituality in the Clinic

Notwithstanding the many critical broadsides leveled by scholars of religion over loose conceptualizations of spirituality as a category of analysis, in the life or death environment that hospice workers inhabit, abstract questions of rhetoric, discourse, generative processes, semantics, shadows, value judgments, and socially constituted practices often fall to the wayside. Whereas scholars are attentive to the way the concept of spirituality serves to draw boundaries between the secular and religion, in clinical settings, spirituality is often regarded as a *real* ontological thing. This allows hospice workers to legitimize their own professional roles as caregivers and healers. As Christina M. Puchalski, a leading physician in the field of spirituality and health, writes: “Spirituality helps people find hope in the midst of despair, find meaning in suffering and increase resiliency against the negative effects of stress. Spirituality is intrinsically linked to the way people find coherence and a sense of authenticity in life.”⁴⁸ In medical parlance, patient spirituality can determine health outcomes such as mortality, coping, and

⁴⁸ Christina Puchalski, “Restorative Medicine,” in *Oxford Textbook of Spirituality in Healthcare*, Mark Cobb, Christina M. Puchalski, and Bruce Rumbold eds. (Oxford: Oxford University Press, 2012), 197. For a review of different definitions of spirituality in healthcare contexts see Ruth A. Tanyi, “Towards Clarification of the Meaning of Spirituality,” *Journal of Advanced Nursing* 39, no. 5 (2002): 500-509; and Jane Dyson, Mark Cobb, and Dawn Forman, “The Meaning of Spirituality: A Literature Review,” *Journal of Advanced Nursing* 26 (1997): 1183-1188.

recovery.⁴⁹ For example, in the United States, where the value of spiritual care is taken for granted, Medicare and Medicaid reimbursement is contingent upon conducting a physical, psychosocial, emotional *and spiritual* assessment of patients within four calendar days after a patient elects to receive the hospice benefit.⁵⁰ But why did attention to the patient's spirituality become such an important component of end of life care? This section will briefly show how spirituality became a key feature of the discourse of hospice care worldwide in order to help us better understand the final section of this chapter which shows how Japanese hospice workers have appropriated these ideas in their own clinical practices.

Cicely Saunders and the Concept of "Total Pain"

The universalization of spirituality as a global dimension of health owes a special debt to Cicely Saunders, who as already mentioned in previous chapters, is regarded as the mother of modern hospice care. Saunders, who started the first modern hospice in Britain in the 1960s, described the patient's "total pain" as having physical, emotional, social, and spiritual components.⁵¹ Saunders stated: "Not many people are likely to express the suffering of their doubts and griefs in religious terms. Nevertheless, feelings of failure, regret and meaninglessness which may be the deepest element in the 'total pain' are spiritual needs."⁵² For Saunders, spiritual pain was most often experienced as meaninglessness. For instance, Saunders cites Viktor Frankl's book, *Man's Search for Meaning*, which argues that the primary concern of

⁴⁹ Christina Pulchalski, "The Role of Spirituality in Healthcare," *Proceedings (Baylor University, Medical Center)* 14, no. 4 (2001): 352-357. For another

⁵⁰ Center for Medicare and Medicaid Services, "Medicare and Medicaid: Hospice Conditions of Participation," *Federal Register* 5, no. 73 (2008): 32167-168.

⁵¹ Cicely M. Saunders, *Cicely Saunders: Selected Writings 1958-2004* (New York: Oxford University Press, 2006), 166.

⁵² *Selected Writings*, 180.

mankind is a search for meaning, and that the will to meaning is what gives us the will to live.⁵³ Drawing on Frankl, Saunders suggested that “patients need to look back over the story of their lives and believe that there was some sense in them and also to reach out towards something greater than themselves, a truth to which they can be committed.”⁵⁴ In Saunders’ case, the search for “something greater” was informed by her belief that it was through faith in God that spiritual pain could most effectively be healed. Although Saunders made a point to define spiritual pain in nonreligious terms and strictly warned against proselytization of patients, she also prayed that patients would see Christ’s suffering on the cross and hoped “that such love will be fully revealed to all as they die and pass into the Presence.”⁵⁵

One often-overlooked aspect of Saunders’ understanding of total pain is the fact that she saw the components of total pain as artificial distinctions whose value was chiefly heuristic. For example, in 1989, she recalls a patient who taught what pain at the end of life feels like.

“Pain? It was *all* pain,” said one old lady in response to my question. And from her reply and that of many others developed the concept of a “total pain,” composed not only of physical elements but also psychological, social and spiritual factors. This somewhat artificial division of a whole overwhelming experience helped in my own understanding and also in an increasing teaching commitment.⁵⁶

Later, in 1996 Saunders wrote:

It soon became clear that each death was as individual as the life that preceded it and that the whole experience of that life was reflected in a patient’s dying. This led to the concept of “total pain,” which was presented as a complex of physical, emotional, social, and spiritual elements. The whole experience for a patient includes anxiety, depression, and fear; concern for the family who will become bereaved; and often a need to find some meaning in the situation, some deeper reality in which to trust.⁵⁷

⁵³ *Selected Writings*, 218; “Facing Death,” *The Way* (October 1984): 301; “Spiritual Pain,” *Contact* 122 (October 1991): 6-9.

⁵⁴ Cicely Saunders and Mary Baines, *Living with Dying: The Management of Terminal Disease* (Oxford: Oxford University Press, 1989), 53.

⁵⁵ Saunders, “Facing Death,” 302-303.

⁵⁶ Saunders, *Selected Writings*, 226.

⁵⁷ Cicely Saunders, “A Personal Therapeutic Journey,” *British Medical Journal* 313, no. 7072 (1996):

Here, Saunders articulates a view of spiritual pain as an “artificial division” that belies the “complex” of total pain. Spiritual pain was simply one way to emphasize the complexity of pain experienced by a *total* person. Nevertheless, as Saunders’ concept of total pain was popularized in hospice care literature, the idea that every person is composed of these four dimensions (physical, psychological, social, and spiritual) would eventually become a fundamental tenet of hospice care—including in the World Health Organization’s definition of health.

WHO’s Definition of the “Spiritual”

In addition to Saunders’ concept of total pain, the World Health Organization’s definition of palliative care has been particularly influential in stimulating Japanese discourse on definitions of spirituality in health settings. The WHO definition reads as follows:

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.⁵⁸

Here, the WHO follows Saunders in suggesting that pain at the end of life is manifested in physical, psychological, social, and spiritual ways. Most Japanese studies on spiritual pain also begin with the WHO’s definition to show Japan’s need to “catch up” with the world in providing spiritual care in the hospice.⁵⁹ The legitimizing effect of the WHO’s definition on the perceived need for spiritual care in Japan was compounded in 1998 when a proposed revision to the

1600.

⁵⁸ World Health Organization, “WHO Definition of Palliative Care,” accessed May 24, 2016. <http://www.who.int/cancer/palliative/definition/en/>.

⁵⁹ For an example, see Tanida Noritoshi, “Supirichuaru kea: Komyunikeshon kara no tenkai,” in *Taiwa, komyunikeshon kara manabu supirichuaru kea: Kotoba to monogatari no jissen*, Tanida Noritoshi, Ōshita Daien, Itō Takaaki eds. (Tokyo: Shindan to Chiryōsha, 2011), 2.

definition of health in the preamble of the WHO's constitution suggested the inclusion of the words "dynamic" and "spiritual." The original text read, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The proposed revision read as follows, "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity."⁶⁰ The proposed addition of the word "spiritual" to the definition of health in the WHO constitution was reported with great interest in Japan.⁶¹ Although the proposal was ultimately shelved for future study, subsequent studies of spiritual care in Japan often cite this proposed revision to the WHO's definition of health as evidence that spiritual care represents an indispensable component of medical care more broadly.⁶²

But what did the WHO actually mean by "spiritual"? In July of 1989, the WHO Expert Committee on Cancer Pain Relief and Active Supportive Care met in Geneva, where part of their discussion touched on the topic of spiritual care. In their report, the WHO defined the "spiritual" as:

...those aspects of human life relating to experiences that transcend sensory phenomena. This is not the same as "religious," though for many people the spiritual dimension of their lives includes a religious component. The spiritual aspect of human life may be viewed as an integrating component, holding together the physical, psychological and social components. It is often perceived as being concerned with meaning and purpose and, for those nearing the end of life, this is commonly associated with a need for forgiveness, reconciliation and affirmation of worth.⁶³

⁶⁰ World Health Organization, "WHO Definition of Health," accessed May 4, 2012. <http://www.who.int/about/definition/en/print.html>.

⁶¹ Kasai Kenta traces the source of this interest to an article published in the *Nihon keizai shinbun* in February of 1999. Kasai Kenta, "WHO ga 'spirituality' gainen no hyōjyunka o motometa kei ni tsuite," *Kokusai shūkyō kenkyūjo nyūzu retā* 38 (March 2003), accessed March 11, 2016, <http://www.circam.jp/files/user/activities/download/02/kk01.pdf>.

⁶² For example, see Mitsuhashi Niki and Toda Yumiko, "Kanwa kea byōtō kangoshi ga toraeru shūmatsuki gan kanja no higengoteki na supirituaru pein no sigunaru," *Kochi daigaku kangogakkai shi* 5, no. 1 (2011): 3-10.

⁶³ WHO Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and*

It is significant that the WHO suggested that the spiritual dimension was not necessarily reducible to the physical, psychological, and social dimensions of personhood, but served as an integrating component for these other dimensions. John Mauritzen, whose essay on spiritual care is cited in the WHO definition, argued that the “spiritual dimension” is the agent that integrates the soma, psyche, and social into an individual “I” which is more than just the sum of all the dimensions. In short, the “spiritual” does not necessarily refer to some individuated dimension of personhood per se, but is equivalent to human existence itself. Accordingly, spiritual pain is often expressed in terms of meaning and purpose, which concern reasons for individual existence.⁶⁴ Like Saunders, the WHO’s aim in addressing spiritual care was to expand the scope of hospice care so that medical workers could see the patient as having more than just physical or psychological needs—a perspective still lacking in many hospitals. For both Saunders and the WHO, invoking the “spiritual dimension” was simply to say that patients needed to be treated holistically, whether they were religious or not.

The Medicalization of Spirituality

Although global recognition of the concept of spiritual pain was welcomed by clinicians concerned about the cold medicalized aspects of treating dying patients, some practitioners also voiced concern that by being welcomed into clinical settings, spiritual care itself was in danger of becoming medicalized, professionalized, and routinized. These worries were voiced, for instance, by Ann Bradshaw, a scholar of nursing, who compared the hospice movement’s original ethos under Saunders’ leadership, and its ethos in the mid-1990s, to argue that “the

Palliative Care: Report of a WHO Expert Committee (Geneva: WHO, 1990), 50-51.

⁶⁴ John Mauritzen, “Pastoral Care for the Dying and Bereaved,” *Death Studies* 12, no. 2 (1988): 117.

charismatic leader is inspired by a spiritual ideal into the founding of a great work, but eventually the spirit attenuates and is lost, and the work itself becomes rationalized and bureaucratized.”⁶⁵ More recently, physician and ethicist Jeffrey Bishop also bemoaned the marginalization of religion in care for the dying:

With the assessment of spiritual care and the deployment of spiritual therapy, religion becomes the handmaiden of medicine. We encounter a total transformation of the idea of hospitality. Whereas the care of the dying, the ill, and the poor was once a handmaiden to the theological virtue of hospitality, now spirituality becomes the professionalized domain of a totalizing medicine.⁶⁶

Bishop argues that Saunders’ vision for hospice care would be considered inadequate today. After all, “to sit with someone holding her hand as she dies; that does not require the prowess of medical science.”⁶⁷ In order for chaplains to prevent themselves from being both institutionally and ideologically marginalized in their work, they must strike an awkward balance between embracing and distancing themselves from the language of medicine and religion as they describe their work.⁶⁸ This suggests how framing their work as “spiritual” also allows chaplains to maintain or contest the acceptable parameters of religious care for patients in medicalized settings that are focused on assessment of patient outcomes.

Perhaps even more troubling to some proponents of spiritual care is the way that attending to a patient’s spirituality not only fails to challenge the clinical gaze but also actually encourages it. As David Clark, a biographer of Cicely Saunders notes:

On the other hand there is something slightly imperialist about a concept like

⁶⁵ Ann Bradshaw, “The Spiritual Dimension of Hospice: The Secularization of an Ideal,” *Social Science and Medicine* 43, no. 3 (1996): 413.

⁶⁶ Jeffrey Paul Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, Indiana: University of Notre Dame Press, 2011), 274.

⁶⁷ Bishop, *The Anticipatory Corpse*, 263.

⁶⁸ Frances Norwood, “The Ambivalent Chaplain: Negotiating Structural and Ideological Difference on the Margins of Modern-Day Hospital Medicine,” *Medical Anthropology* 25, no. 1 (2006): 1-29, accessed April 2, 2016, doi: 10.1080/01459740500488502.

“total pain.” Note the elision from an initial focus on the physical sensation of pain, to a wider and deeper searching for signs of trouble, in the social network, in the psyche, even in the soul itself. From this perspective the unlocking key has become an instrument of power. This is of course not a sovereign power of coercion, but rather a disciplinary power rooted in knowledge and the technologies of care. “Total pain” thus becomes an elaboration of the clinical gaze, a new mode of surveillance and an extension of medical dominion.... So in resisting one form of disciplinary power (the dominant discourse of biomedicine) there is a risk of creating another. Indeed this may be unavoidable, even if that new discourse, as Cicely Saunders so clearly intended, is kinder and gentler.⁶⁹

As these authors point out, for all its good intentions, the integration of spiritual care within hospice care is not immune to the clinical gaze of which Foucault has warned. Naturally, this also undermines its original holistic ethos.

The medicalization of spiritual care in ways that turns the “holding the hand of a patient” into a technology of care that can be quantified and assessed through the clinical gaze takes the chaplain, a medical outsider, and makes him or her a medical insider. But in doing so, the role and responsibilities of the chaplain must also be defined in relation with the duties of other members of the medical team. This can sometimes create confusion about the chaplain’s role when duties overlap. For instance, the work of the chaplain is very closely related to the work of clinical psychologists who provide patients with psychological care.⁷⁰ Since Saunders herself drew on Frankl’s humanistic psychology, it is not always clear how spiritual care differs from Frankl’s brand of psychotherapy.⁷¹ Saunders cites Frankl’s logotherapy and his emphasis on “man’s search for meaning” as keys to understanding spiritual pain. But Saunders glosses over the fact that Frankl himself does not use the word spiritual, but speaks of *existential* frustration or

⁶⁹ David Clark, “‘Total Pain’, Disciplinary Power and the Body in the Work of Cicely Saunders, 1958-1967,” *Social Science and Medicine* 49, no. 6 (1999): 734.

⁷⁰ This question was voiced as early as 1933 by Carl Jung in a book chapter titled: “Psychotherapists or the Clergy.” C.G. Jung, *Modern Man in Search of a Soul*, trans. W.S. Dell and Cary F. Baynes (New York: Harcourt, 1933).

⁷¹ Tony Walter, “The Ideology and Organization of Spiritual Care: Three Approaches,” *Palliative Medicine* 11, no.1 (1997): 26.

distress.⁷² Thus Saunders' appropriation of Frankl indicates that spirituality represents not only a relabeling of religion but of humanistic psychology as well.⁷³ Or, put another way, if the well known psychologist of dying, Elizabeth Kübler-Ross, were alive today, she would likely "be doing spirituality, not psychology."⁷⁴

Legalizing Spirituality

The application of spirituality in global health care settings has also been shaped by legal concerns. For instance, in a study of chaplaincy programs in the United States, Winnifred Fallers Sullivan shows how spiritual care in American hospitals continues to be shaped by legal decisions that reflect the balancing act chaplains must perform as religious professionals working in secular spaces. In 2005, a legal contest between chaplaincy services at Veteran hospitals and the Freedom from Religion Foundation unfolded in which secular groups complained that the work of chaplains amounted to promotion of religion. Although the chaplaincy services won the court case, they subsequently transformed their spiritual care programs by deliberately incorporating secularizing language to prevent future lawsuits. As Sullivan writes, "Religion in the form of pastoral care had successfully disestablished itself, shedding its problematic religious features, making itself universal, benign, and of public value."⁷⁵ This is not to say that the religious aspects of spiritual care were completely removed. In fact, as Wendy Cadge has shown in her study of religion in American hospitals, medical workers today still openly employ religious language and frames of reference in their care for patients. However, because chaplains

⁷² Frankl, *Man's Search For Meaning* (London: Rider, 2008), 106-108.

⁷³ Lucy Bregman, "Defining Spirituality: Multiple Uses and Murky Meanings of an Incredibly Popular Term," *Journal of Pastoral Care & Counseling* 58, no. 3 (Fall 2004): 158.

⁷⁴ Bregman, "Defining Spirituality," 166.

⁷⁵ Sullivan, *A Ministry of Presence*, 48. Some chaplains also bemoan this shift. Herbert Anderson, "Whatever Happened to *Seelsorge*?" *Word and World* 11, no. 1 (Winter 2001): 32-41.

tend to be more cognizant of their precarious legal position as religious professionals in secular institutions, at times they may actually be *less* likely to openly engage in religious conversations with patients than are other religiously minded medical caregivers.⁷⁶

The move by chaplaincy services in the United States to replace religious language in its manuals with “spiritual” language in the wake of lawsuits also suggests that some of the distinctions between religion and spirituality are more semantic than substantive. For example, one clinical study goes so far as to suggest that the inclusive public language of spirituality—which must be publically presented to patients—has “contaminated” research on those outcomes of spiritual care that are actually grounded in religious involvement.⁷⁷ In short, clinicians acknowledge that at its heart, “spirituality” often serves as a non-threatening and legal euphemism for religion. This further attests to the way that spirituality in the clinic serves to both stand against and alongside religious beliefs and practices.⁷⁸

As this section has shown, spirituality in clinical settings is often treated as an incontrovertible dimension of the patient’s *being*. Saunders theorization of total pain in hospice settings called attention to the “spiritual pain” that patients might feel at the end of life and the importance of treating spiritual pain was further confirmed by the WHO which included spiritual care in their definition of palliative care. Although both Saunders and the WHO emphasized the importance of spiritual care as a way to make palliative care more holistic, the incorporation of spiritual care into clinical settings also made it susceptible to medicalization, in which spiritual care could become a “technology” that required professional prowess. The professionalization of

⁷⁶ Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012), 129.

⁷⁷ Katia Garcia Reinert and Harold G. Koenig, “Re-examining Definitions of Spirituality in Nursing Research,” *Journal of Advanced Nursing* 69, no. 12 (2013): 2622-34

⁷⁸ Tony Walter, “Spirituality in Palliative Care: Opportunity or Burden?” *Palliative Medicine* 16, no. 2 (2002): 133-139.

spiritual care and the integration of chaplains into hospice teams also required outlining the differences between spiritual care and clinical psychology, even though Saunders' view on spiritual care drew heavily from humanistic psychology. Finally, the application of spirituality in clinical settings also raised legal concerns in the United States that put pressure on chaplains to frame their work in secular terms. This shows the way chaplains in clinical settings must maintain a delicate balancing act in which the concept of spirituality serves to demarcate the acceptable parameters of religious care for patients. In the next and final section, we will now see how prominent hospice care workers and scholars in Japan have similarly sought to apply the concept of spirituality in hospice care in ways that make the practice of spiritual care palatable to the medical spaces they work in.

Japanese Appropriations of Spirituality in Hospice Care

Having surveyed the invention of the term “spirituality” in Japan, some scholarly approaches to the study of spirituality, and its application in global clinical settings, this last section will finally turn to how spirituality has been localized in Japanese studies of spiritual care. As noted at the outset of this chapter, Japanese hospice workers like Yamazaki have struggled to understand what lies at the root of “spiritual pain.” When hospice pioneers promoted Saunders’ holistic ideal of hospice care in Japan, the concept of spiritual pain proved remarkably difficult to translate. In the Western context, the tradition of pastoral care in hospital settings provided familiar avenues for developing a theory of spiritual pain and how it should be cared for. But in Japan, the notion that religious professionals could be part of a medical team was unprecedented. Furthermore, in a society with relatively low indicators of religiosity, it was difficult to see what spiritual pain and spiritual care might actually look like. Consequently, after the Japanese

hospice movement gathered momentum in the 1990s, various figures in the hospice movement struggled to demarcate what spiritual pain was and how it should be cared for. This section will detail that struggle.

One of the first themes present in the scholarship of hospice leaders who have tried to implement spirituality in clinical settings is the question of where to locate the “spiritual.” The answer to this question is not simply of metaphysical interest but has important implications for the practice of spiritual care. Namely, one of the ways spiritual care is legitimized is by portraying spirituality as a *dimension of being*. By showing that there is a locus for spiritual pain, hospice workers are able argue for the importance of spiritual care in clinical terms, focused on caring for the patient’s “spirituality.” Another theme is the question of the relationship between the “spiritual” and “religion.” While chaplains with religious backgrounds and training primarily practice spiritual care, the exceedingly negative image of religion in Japan complicates a definition of spirituality that is too closely associated with religion. Accordingly, Japanese hospice workers have carefully outlined the relationship between religion and spirituality in their models of spiritual care, some arguing that they are mostly separate, and others arguing that they are mostly inseparable. Interestingly, while we might assume that this localization and reification of spirituality as a dimension of being and its relationship with religion is articulated very differently by hospice workers based on their religious backgrounds, we actually find that different theories about spirituality and spiritual care do not necessarily break down along denominational lines. This attests to the way these issues are truly trans-denominational, affecting Buddhist and Christian hospice workers alike. Ultimately, however, this localization of spirituality within the bodies of patients is also at odds with Saunders original vision of hospice care of treating patients as a “whole person.”

Locating Spiritual Pain

The first step for hospice workers trying to integrate the concept of spirituality into the Japanese hospice movement was to pinpoint what exactly the “spiritual” dimension of hospice care signified. This included a search for the right translation of the term “spirituality” into Japanese, as well as identification of the types of “spiritual pain.” This search for “spirituality” resulted in a rich array of diagrams that tried to illustrate the differences between the physical, psychological, social, and spiritual dimensions of patients, as well as the differences between “religious pain” and “spiritual pain.”

As one of the leaders of Japan’s hospice movement, Kashiwagi Tetsuo was the first in Japan to explore the concept of spiritual pain. In his 1996 book, *Listening to the Kokoro of Dying Patients*, Kashiwagi devoted an entire chapter to this topic. He begins by introducing a hospice patient who struggled to grasp the meaning behind her suffering. Kashiwagi then described the pain she felt as the pain of her “spirit/soul” (*tamashii* 魂) and explained how this type of suffering was commonly dealt with through spiritual care (*reiteki kea* 霊的ケア) or even religious care (*shūkyōteki kea* 宗教的ケア). He then repeated Saunders’ explication of total pain and translated spiritual pain as *reiteki* pain with the English term “spiritual” next to it in parentheses.

However, Kashiwagi was slightly uncomfortable with this translation. Later in the chapter he explained:

Defining *reiteki* pain is very difficult. This is a translation of the English term “spiritual pain.” It is also possible to translate “spiritual pain” as religious pain (*shūkyōteki itami* 宗教的痛み) but then the meaning becomes too narrow. When we think of spiritual pain narrowly as religious pain, there are patients who hardly have spiritual pain. I think it is better to interpret this more broadly. Accordingly, instead of *reiteki* pain, I think pain of

the *tamashii* might be a better translation. If so, almost all patients could be said to have some sort of spiritual pain, whether big or small.⁷⁹

Here Kashiwagi resorts to the word *tamashii*, which D.T. Suzuki initially rejected as a translation for “spiritual” since he felt it was “like a round object that might roll before your eyes.” However, for Kashiwagi, a committed Christian, the term *tamashii* was a familiar Biblical term.⁸⁰

Kashiwagi then went on to classify spiritual pain into seven different types.

1. Questioning the meaning of life. (*jinsei no imi e no toi* 人生の意味への問い)
2. Changes in one’s value system (*kachitaikei no henka* 価値体系の変化)
3. The meaning of suffering (*kurushimi no imi* 苦しみの意味)
4. Consciousness of guilt (*tsumi no ishiki* 罪の意識)
5. Fear of death (*shi no kyōfu* 死の恐怖)
6. Seeking whether God exists (*kami no sonzai e no tsuikyū* 神の存在への追求)
7. Worries about perspectives on life and death (*shiseikan ni taisuru nayami* 死生観に対する悩み)⁸¹

As this list shows, Kashiwagi’s definition of spiritual pain closely followed Saunders’ emphasis on dying patients’ struggle over meaninglessness, guilt, and a search for God. Kashiwagi also viewed spiritual pain as a mixture of existential and religious concerns. Although Kashiwagi emphasized that personal beliefs should never be imposed on patients, as a Christian doctor, he also suggested that forming a connection with a higher power was the most effective treatment for spiritual pain. For example, he states that while “relief” (*anshin* 安心) for patients may come from horizontal (*yoko* 横) relationships, ultimately, “peace” (*heian* 平安) only comes from vertical (*tate* 縦) relationships with higher powers.⁸² He also notes that in addition to staying,

⁷⁹ Kashiwagi Tetsuo, *Shi ni yuku kanja*, 114-115.

⁸⁰ *Tamashii* is used throughout the Japanese Bible (New Interconfessional Translation Bible), including 108 times in the Psalms alone. For instance, the well known Davidic psalm, “The Lord is my Shepherd” (Psalm 23), includes the line “He [the Lord] restores my *tamashii*.”

⁸¹ Kashiwagi, *Shi ni yuku kanja*, 115-117.

⁸² Kashiwagi Tetsuo, “Yamu hito no tamashii ni todoku iryō o motomete,” in *Iyashi o motomeru tamashii no kawaki: Supirichuariti to wa nanika*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku

listening, being honest, open, flexible and accepting of the patient, “witnessing” (*risshō* 立証)” can also play a part in care for the *tamashii*.⁸³

Kashiwagi’s choice to translate spiritual pain as “pain of the *tamashii*” also introduced a slight but significant shift in nuance from Saunders’ explication of spiritual pain. Kashiwagi preferred “pain of the *tamashii*” over “*reiteki* pain” since *reiteki*, which comes from the root *rei*, was often associated with ghosts and other supernatural phenomena. But in translating “spirit” as *tamashii*, Kashiwagi also made a small grammatical change. *Reiteki* is made up the root word *rei* combined with the suffix *teki* to form an adjective modifying the word “pain.” In this regard, it is similar to the English adjective “spiritual” modifying the noun “pain.” However, Kashiwagi used the subject noun *tamashii* followed by the possessive particle *no* and the object noun *itami* (pain). It is literally “pain of the spirit.” In so doing, Kashiwagi inadvertently provided a locus for pain, by introducing the *tamashii* or “spirit” as a discrete subject of pain.

It was natural for Kashiwagi to see the *tamashii* as the locus of pain since he believed that humans are made up of a body (*karada* 身体), heart/mind (*kokoro* 心), and spirit (*tamashii* 魂).⁸⁴ This tripartite definition of personhood was in fact part of the founding motto of Yodogawa Christian Hospital where Kashiwagi worked. The hospital stated its mission as dedication to “whole person healing, a medical ministry in Christ’s love, serving the patient as a total unity of body (*karada*), mind (*kokoro*), and spirit (*tamashii*).”⁸⁵ As it turned out, however, Kashiwagi’s preference for the word *tamashii* would be abandoned in hospice care literature and hospice workers ultimately adopted the practice of leaving the term “spiritual pain” untranslated

shuppankai, 2011), 42.

⁸³ Kashiwagi, *Shi ni yuku kanja*, 119.

⁸⁴ Kashiwagi, “Yamu hito no tamashii,” 40.

⁸⁵ YCH Website. Accessed January 21, 2016. <http://www.ych.or.jp/en/aboutus.html>.

and simply transliterated into *katakana* syllabary as *supirichuaru pein*.⁸⁶

The eventual decision by hospice workers to not use the Japanese word *tamashii* as a translation for “spirituality” and to rely on an English loan word instead tells us several things. Typically, loan words in Japanese serve multiple functions. For example, they can mark a word as “new” or “up to date,” as well as “Westernized” or “prestigious.” In addition, they can also serve as a euphemism for a native Japanese word that has negative connotations.⁸⁷ In the case of “spirituality,” we see all these functions. By employing an English loanword, “spirituality,” hospice workers signaled that this concept was on the front lines of medical care and reflected the most up to date Western style medicine. More importantly, as a loan word, “spirituality” allowed chaplains to legitimize their work as religious professionals in medical spaces without drawing on words like *tamashii* or *reisei*, which had stronger associations with religion or the paranormal. Kashiwagi himself later adopted this convention of referring to “*supirichuariti*” as the object of spiritual care.⁸⁸

Although Kashiwagi ultimately did not set forward a detailed vision of what spiritual care entails, his work helped spark a conversation that would be carried on by chaplains and scholars who later dedicated themselves to examining in even more detail their understanding of what spiritual care and spiritual pain actually mean for Japanese patients. One such chaplain who elaborated on a theory of the spiritual dimension of health and helped provide a locus for spiritual pain was Waldemar Kippes, a German Catholic missionary and founder of Japan’s earliest spiritual care training program. In 1999, he published a book in Japanese titled, *Spiritual*

⁸⁶ Some exceptions include: Fujii and Fujii, *Tamashii no kea* and Tanida, “Supirichuaru kea,” 2-11.

⁸⁷ Bates Hoffer, “English Loanwords in Japanese: Some Cultural Implications,” *Language Sciences* 12, no. 1 (1980): 12-15.

⁸⁸ Kashiwagi, “Yamu hito no tamashii,” 39. Though as recently as 2015, when pressed, Kashiwagi still admitted a preference for the word *tamashii*. Panel Discussion, Japan Society for Spiritual Care Annual Conference, Koyasan University, Wakayama, September 13.

Care: Kokoro Care for the Sick, their Families, Friends and Medical Staff. In the opening pages of this book, Kippes paid careful attention to the concepts and terms that informed the practice of spiritual care. He noted that the foundation for spiritual care required an understanding of what the “spirit” is. Without such an understanding, terminology such as spiritual needs, spiritual suffering, spiritual cry, spiritual comfort, and spiritual healing would be meaningless.⁸⁹ After acknowledging that Cicely Saunders and the WHO had identified four dimensions of personhood, Kippes provided his own schematic diagram that included six dimensions.

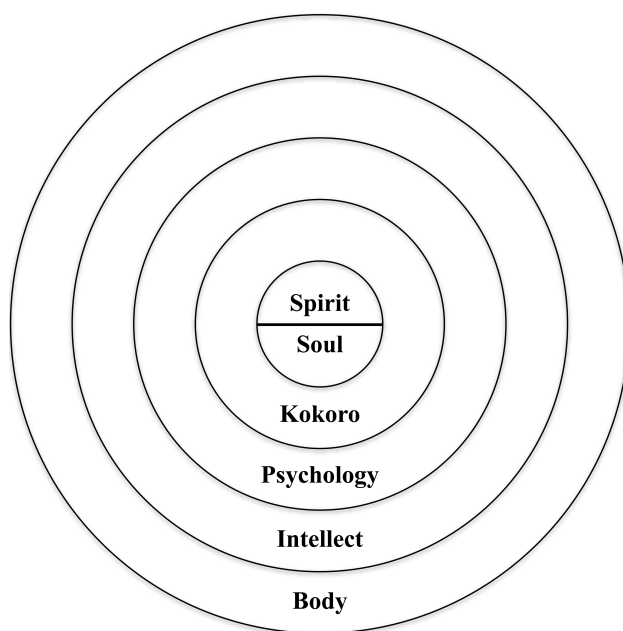


Figure 2. Human Dimensions (*Ningen no jigen* 人間の次元)⁹⁰

Like Kashiwagi, Kippes explains that at the core of every person lies a soul (*tamashii* 魂), which represented the eternal self of personhood, as well as a spirit (*rei* 霊), which represents the

⁸⁹ Waldemar Kippes, *Supirichuaru kea: Yamu hito to sono kazoku, yūjin oyobi iryō sutaffu no tame no kokoro no kea* (1999; reprint, Tokyo: San Paulo, 2010), 58.

⁹⁰ Kippes, *Supirichuaru kea*, 34.

“breath” (*iki* 息), or “life” (*inochi* 命), that animated all the other dimensions. Surrounding the soul and spirit lies the *kokoro*, which represents one’s moral conscience and volition. Beyond the *kokoro* lies the psychological (*shinri* 心理), which represents the emotional dimension of a person including the instinctive, unconscious, and subconscious. Kippes also points out that it is often difficult to distinguish between the *kokoro* and the psychological but suggests that the latter is part of a field of scientific inquiry while the former is not. Beyond the psychological lies the intellect (*chisei* 知性), which is firmly lodged in the brain. All of this is then manifested in the physical body (*shintai* 身体).

Kippes stresses in the beginning of his book that all these dimensions are part of *one* integrated organic body; he also notes that the needs, pains, and cries that arise in each dimension differ and require different approaches for care and cure.⁹¹ But in the remainder of the book, Kippes focuses on the “spirit” which he believes to be the primary object of spiritual care.⁹² Although he does not use the term “spirituality,” he describes persons as having a “spiritual existence.” Kippes’ usage of the term “spiritual” is therefore consistently adjectival, describing that which relates to the core object of spiritual care—the spirit. Like Kashiwagi, he conceived of the spirit as something that lay *within* the person, and as a discrete component of human *being* alongside the physical, and psychological dimensions of personhood.

While Kashiwagi and Kippes both sought to illuminate the locus of spiritual pain and its underlying causes, another key figure in the development of Japanese models of spiritual care,

⁹¹ Kippes, *Supirichuaru kea*, 33-37.

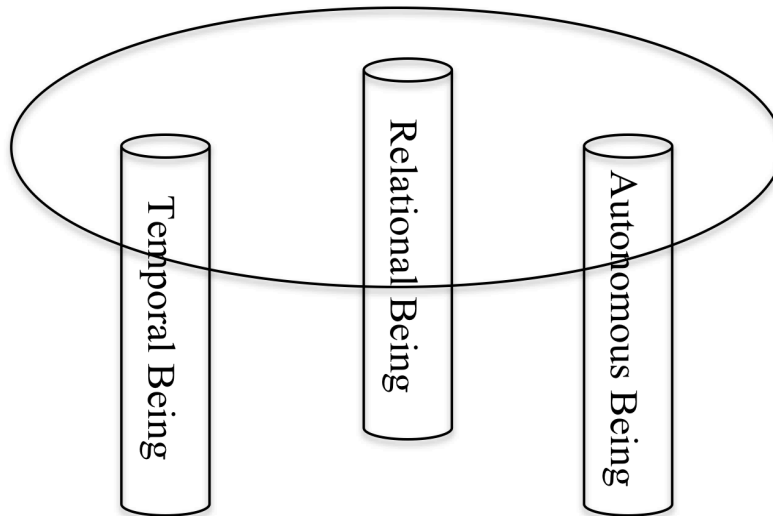
⁹² In his native German, Kippes focuses on *geist* (spirit) rather than *seele* (soul) as the locus of spiritual care. In Germany, spiritual care is most commonly referred to as *seelesorge* (lit. soul care), which is conducted by a *seelesorger*. Kippes is obviously not unaware of this, but chooses to focus on the alternative term for chaplain, *geistlicher*, which allows him to make his point about the centrality of the *geist* as the object of spiritual care. Kippes, *Supirichuaru kea*, 156.

Murata Hisayuki, sought to focus instead on how spiritual pain *feels*. In other words, Murata explained spiritual pain in terms of its symptoms rather than its etiology. Thanks to the simplicity of his model, Murata's definition of spiritual pain remains one of the most frequently cited in hospice journals and one that was brought up frequently in my interviews with nurses and doctors. Murata, a Catholic professor of philosophy, first defined spiritual pain as the "pain that arises from the extinction of the being and the meaning of self," and then suggested that it is felt in three distinct ways: as temporal beings (*jikan sonzai* 時間存在) which includes fear of losing the future and personal reflections on the meaning of life; as relational beings (*kankei sonzai* 関係存在) which includes fear of loneliness, alienation, being misunderstood; and as autonomous beings (*jiritsu sonzai* 自律存在), which includes fears of being physically incapacitated, or a burden on others.⁹³ Another attraction of Murata's definition was that it made spiritual pain more concrete. As I will demonstrate in later chapters, "spiritual pain" is not a meaningful term for Japanese patients themselves. Murata's definition of spiritual pain agrees with Kashiwagi and Kippes in that it concerns questions surrounding individual meaning and existence in the face of suffering. However, Murata recognized that unless patients framed their spiritual pain in those exact words—which they usually did not—it remained hard to detect in clinical practice. Murata's definition helped solve this conundrum for spiritual care practitioners by paying closer attention to how meaninglessness is *experienced* and *expressed*. This helped hospice staff more easily diagnose patients with spiritual pain even when patients did not express their concerns in explicitly existential or religious terms. For instance, one study utilized Murata's definition to discuss a patient who voiced a deep fear that she would become an object of gossip if her friends

⁹³ Murata Hisayuki, "Shūmatsu gankanja no supirituraru pein to sono kea," *Nihon pein kurinikku gakkai* 18, no. 1 (2011): 1-8. Also Murata, "Supirichuaru pein no kōzō to kea no shishin," *Tāminaru kea* 12, no.6 (2002): 521.

became aware of her condition.⁹⁴ In this case, she was diagnosed as suffering from a relational form of spiritual pain and was given a care plan that restricted visits from non-family members. Another patient expressed dismay at the loss of her normal active life. She in turn was diagnosed as suffering from spiritual pain related to loss of autonomy and was prescribed a care plan of providing her with a portable oxygen cylinder so that she could leave her bed more often—thus helping restore a measure of autonomy.

Others have also expanded on Murata's model. An example is Ozawa Taketoshi, a hospice physician who in 2008 wrote a book with the handy title, *Practical Spiritual Care for Medical Workers: Don't Run from Suffering Patients!* He explained that his book was based on, and sought to clarify, Murata's explanation of spiritual care in a way that it could be applied even more practically in medical settings. First, to illustrate spiritual pain, he used the following diagram.



⁹⁴ Hashiguchi Reiko, Miyazaki Yuriko, and Sakamoto Megumi, “Shūmatsu kanja no supirichuaru pein e no kango no imi: Murata riron ‘supirichuaru pein no sonzairon’ o mochiita bunseki kara,” *Nihon kango gakkai ronbunshū, seijin kango II* 41 (2000): 4.

Figure 3. Three Supports for Existence⁹⁵

As this diagram shows, patients are maintained by three pillars that correspond to the three aspects of being outlined by Murata. Ozawa then developed a series of additional diagrams to illustrate how if one of the pillars collapses, the plate on top will tip and create a crisis for the patient. For example, if the temporal pillar breaks due to the patient's fear of what lies beyond death, the plate will begin to tip. According to Ozawa, one way to restore balance was to help the patient realize how much he or she is loved and supported by family, hospice staff, and others. By "strengthening" the relational pillar, the plate could be restored to balance even after the loss of the temporal pillar. Alternatively, if the patient is led to realize that, even after death, there is an afterlife where he or she could reunite with family members, the temporal pillar will be mended and balance is restored. In Ozawa's view, helping to keep the patient supported as their existential pillars are weakened at the end of life was the important function of spiritual care.

Perhaps the most distinctive aspect of Murata and Ozawa's theory of spiritual pain is its lack of a mention of the explicitly religious concerns we find in Kashiwagi and Kippes understanding of spiritual pain. Instead, religious concerns are included within the three aspects of being. For instance, when patients feel cut off from a transcendent Being, this can be labeled as a form of relational pain. Likewise, questions about the future or afterlife fall under the category of temporal spiritual pain. As I will discuss next, the varying degrees to which spirituality and spiritual pain are linked to religion is an important concern of hospice leaders who are invested in the promotion of spiritual care.

⁹⁵ Ozawa Taketoshi, *Iryōsha no tame*, 67.

The Tension Between Spiritual and Religious Care

Although figures like Kashiwagi and Kippes helped set some of the parameters for the study of spiritual pain, and also identified its locus in the early days of the hospice movement, subsequent leaders in the spiritual care sought to more carefully delineate the role that religion plays in spiritual care. Buddhist and Christian chaplains were well aware, particularly after the Aum sarin gas incident, that the success of spiritual care in clinical settings required sensitivity on the part of chaplains to the broader negative image that many Japanese had of religious professionals. At the same time, chaplains could not deny that their religious background and training informed their work. As the next few pages will show, the boundary making function of spirituality afforded chaplains a means to maintain this delicate balancing act. This process of negotiation also helped produce different conceptualizations of the relationship between spirituality and religion.

One of the first figures who set about distinguishing religious care from spiritual care and also helped set the tone for theoretical literature on spiritual care was Kubotera Toshiyuki, a former Christian chaplain at Yodogawa Christian Hospital. Kubotera was an ordained Christian minister who worked with Kashiwagi as a chaplain at Yodogawa Christian Hospital for several years before transitioning to an academic career. In his first major book on the subject, published in 2000, Kubotera began by defining spirituality.

Spirituality (*supirichuariti*) is the function of seeking out a new place of support, in something larger and outside of yourself, in order to live through a crisis or find hope, when faced with a crisis in life that shakes your support system, or when you lose sight of this support. It is also the function of seeking within yourself new meaning or goals for life when these are lost in a crisis.⁹⁶

He also defined spiritual pain as “the pain felt in one’s whole existence when the reason and

⁹⁶ Kubotera, *Supirichuaru kea nyūmon*, 13.

meaning for living is threatened by illness or death.” Thus, as patients feel threatened by death, a higher consciousness of “self” raises emotional, philosophical and religious questions.⁹⁷ Like Saunders and Kashiwagi, Kubotera also saw spiritual pain manifest itself in explicitly religious concerns regarding the afterlife or God as well as broader existential concerns such as the meaning of life or suffering. In addition, Kubotera saw religious concerns as important even when they were not evident. For example, he believed that, while spiritual pain could be manifested as psychological stress, beneath the psychology might lie deeper philosophical doubts, religious questions, and a desire for relief (*kyūsai* 救済).⁹⁸ In other words, Kubotera argued that humans naturally seek out God, eternity, meaning, or value in their lives.⁹⁹ Kubotera further suggested that when difficulties come, those who have a strong relationship with God are better prepared to cope.¹⁰⁰

However, despite the fact that Kubotera believe that religious concerns were a significant factor in the spiritual pain of patients, one of the significant features of Kubotera’s theory of spiritual care was that religious care must be clearly distinguished from spiritual care. For example, in the following diagram, Kubotera laid out his understanding of “*kokoro* pain.”

⁹⁷ Ibid., 43.

⁹⁸ Kubotera, “Supirichuaru pein no honshitsu to kea no hōhō,” *Kanwa kea* 15, no. 5 (2005): 392.

⁹⁹ Some have been wary of this approach. For example, Ida Hiroyuki has expressed doubts caution over Kubotera’s theistic overtones. “Supirichuaru kea o meguru giron,” *Osaka keidai ronshū* 54, no. 5 (2004): 333-64.

¹⁰⁰ Kubotera Toshiyuki, “Ikiru imi o motomete: Hosupisu no keiken kara kangaeru,” in *Supirichuaru pein ni mukiau: Kokoro no annei o motomete*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku Shuppankai, 2011), 126.

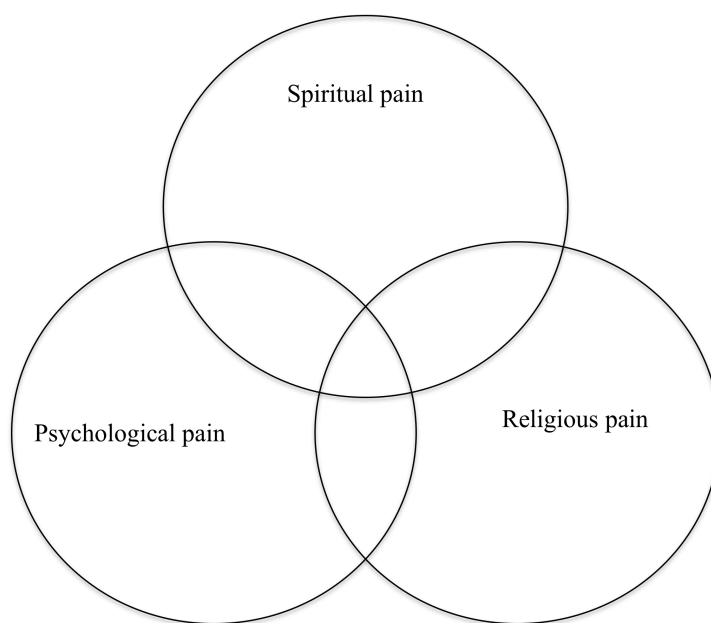


Figure 4. *Kokoro* pain

As this diagram illustrates, despite some overlap, religious pain and psychological pain are viewed as distinct from spiritual pain. Like most chaplains, Kubotera strictly opposed the proselytization of patients. Clearly, this would be a violation of patient rights. Not only was the indiscriminate provision of religious care to all patients impolitic, he said, but religious care was actually predicated on a very different kind of pain. He explained that while spirituality is centered on “healing” (*iyashi* 癒し), religion is centered on “salvation” (*sukui* 救い).¹⁰¹

Kubotera also argued that while religious care puts forward doctrinal answers to questions of the afterlife, spiritual care affirms the patients own beliefs; while religious care might pronounce forgiveness, spiritual care helps patients quietly accept their guilt, help them reflect, or forgive themselves; and while religious care is offered by a religious professional, the providing of

¹⁰¹ “Supirichuariti to kokoro no enjo,” 23.

spiritual care is not limited to religious experts.

One way that Kubotera was able to make this distinction between religious and spiritual care was by focusing on a patient's "spirituality" (*supirichuariti*) as the locus of spiritual pain. Whereas Kashiwagi and Kippes initially preferred to speak of the *tamashii* or *rei* that resided within patients, Kubotera describes spirituality as a "function" (*kinō* 機能) that all humans are born with, and that becomes particularly "awakened" (*kakusei* 覚醒) in the face of a crisis.¹⁰² In Kubotera's view, spirituality could be described in three ways: as feelings (*kankaku* 感覚), reasons for living (*ikiru konkyo* 生きる根拠), or as one's identity. By feelings, Kubotera referred to phenomenological experiences of sacredness or things that lie outside of common experience. By reasons for living, he referred to the fact that spirituality could provide a framework (*wakugumi* 枠組み) that helps situate oneself in life and establishes a foundation of values that help make life worth living. Finally, as an identity, spirituality was also an awareness of oneself as distinct from others.¹⁰³

Although Kubotera noted that religion could play a positive role in spiritual care, his emphasis on a patient's "spirituality" as the source of spiritual pain helped provide the first meaningful distance between religious and spiritual care.¹⁰⁴ This distance also helped turn the concept of spirituality into something more discrete. This is seen for instance in Kubotera's tendency to personify spirituality. In Kubotera's words, spirituality is something that is "seeking"

¹⁰² Kubotera Toshiyuki, "Jiko to supirichuariti," in *Zoku supirichuaru kea o kataru*, Kubotera Toshiyuki and Hirabayashi Takahiro eds. (Hyogo: Kwansei Gakuin Daigaku Shuppan, 2009), 13.

¹⁰³ Kubotera also outlines four ways spirituality is formed: the cultural milieu one is born into, social relations, philosophy, and religion. Kubotera, "Jiko to supirichuariti," 14-17.

¹⁰⁴ Kubotera Toshiyuki, "Supirichuaru kea e no shūkyō no kōken: Shūkyō no fukken ni mukete," *Shūkyō kenkyū* 84, no. 2 (2010): 79-104.

(*motometeiru* 求めている), “awakes” (*kakusei* 覚醒), and “sleeps” (*nemutte* 眠って).¹⁰⁵

This personification also mirrored a broader trend in Japanese medical literature to nominalize the term “spiritual” through phrases like “from now on, spiritual is going to be important” (*kore kara wa supirichuaru ga jūyō de aru*) or “pay attention to the patient’s spiritual (*kanja no supirichuaru ni chūmoku shinakereba naranai*).”¹⁰⁶

Another scholar who emphasized the need to separate religious care from spiritual care was Taniyama Yōzō, a former Buddhist hospice chaplain and professor at Tohoku University. Taniyama remains one of the most prominent Buddhist commentators on the subject of spiritual care and presents the following diagram to explain how spiritual care is structured in terms of relationships.

¹⁰⁵ Kubotera Toshiyuki, “Supirichuaru na mono e no tamashii no sakebi,” in *Iyashi o motomeru tamashii no kawaki: Supirichuariti to wa nanika*,” ed. Kubotera Yoshihuki (Saitama: Seigakuin Daigaku Shuppankai, 2011), 151, 152, 158. This is also echoed by other authors. For example, Hirayama talks about the “work” (*hataraki*) of spirituality. Hirayama Masami, “Hitan to supirichuaru kea,” in *Iyashi o motomeru tamashii no kawaki*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku Shuppan, 2011), 124, 126.

¹⁰⁶ The nominalization of “spiritual” is important since it suggests that it is a discrete “thing.” As an adjective, the “spiritual” becomes thinner, and its meaning becomes wider. Andō, “‘Supirichuariti’ gainen no saikō,” 8-9.

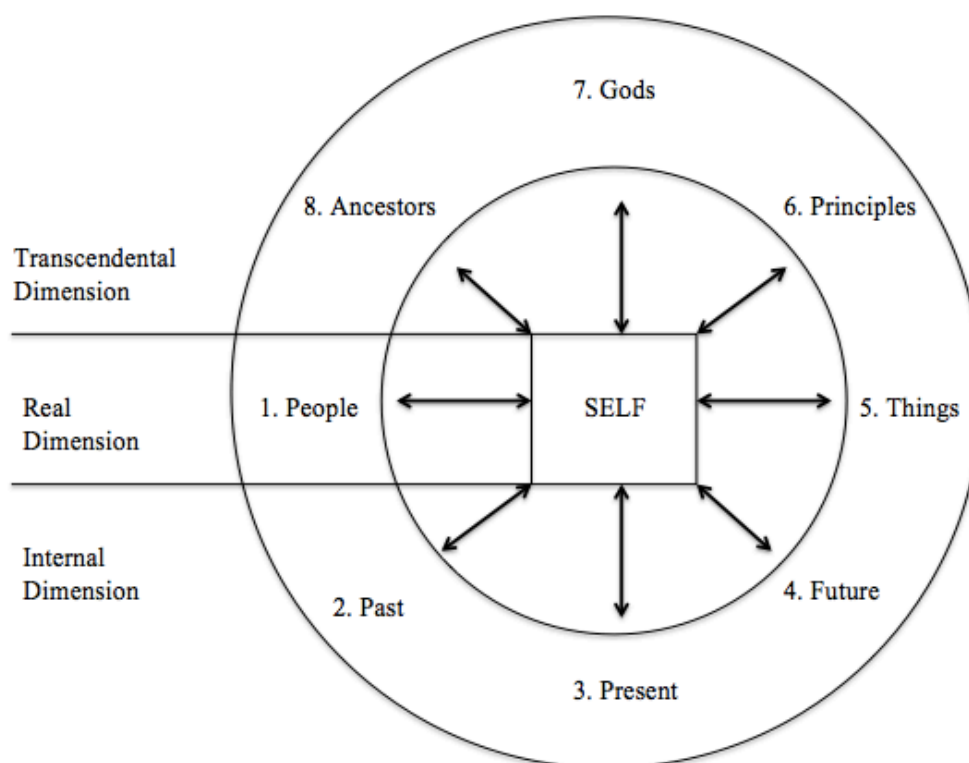


Figure 5. The Structure of Spiritual Care (Taniyama)¹⁰⁷

In this figure, the “self” is located at the center of the circle and is surrounded by eight relations. These include relations with: 1. people (*hito* 人); 2. the past [me] (*kako* 過去); 3. the present [me] (*ima* 今); 4. the future [me] (*mirai* 未来); 5. things (*koto* 事); 6. principles (*ri* 理)¹⁰⁸; 7. gods (*kami* 神); and 8. ancestors (*so* 祖). These relations are further categorized into three dimensions: the transcendent (nos. 6-8), real (nos. 1, 5), and internal (nos. 2-4). Taniyama

¹⁰⁷ Taniyama Yōzō, “Nihonteki, bukyōteki yōso o kuwaeta supirichuaru kea ron,” *Bukkyō fukushi* 10, (2007): 77.

¹⁰⁸ Taniyama defines “principles” as: “the truth of the universe and nature’s providence”; “the sun, moon, and stars,”; “transcendental functions such as dharma, higher power, and the work of the holy spirit”; and “ideals, thought, morals, ethics, mottos.” Taniyama Yōzō, “Supirichuaru no kōzō: Kubotera riron ni Nihon no bukyōsha no shiten o kuwaeru,” in *Zoku, supirichuarukea o kataru*, Kubotera Toshiyuki and Hirabayashi Takahiro eds. (Hyogo: Kwansei Gakuin Daigaku Shuppan Kai, 2009), 77-98.

explains that the numbers affixed to each of these relations also represent the order of the most common types of spiritual pain and suggests that most Japanese tend to be conscious first of other people; then of their past, present and future selves; and finally, of the transcendent.

Like Kubotera, Taniyama makes clear that in practice, religious care, which he defines as a type of care in which the patient is invited to participate in the caregiver's belief system, should be carefully distinguished from spiritual care, in which the caregiver enters the patients belief system.¹⁰⁹ Taniyama's concern about conflating these approaches is twofold. First, he agrees with Kubotera that there is a real danger of coercing vulnerable patients to adopt the caregiver's religion. Thus when a chaplain or staff member sees a need for religious care, they must first confirm this with the patient before drawing on religious resources to provide such care.¹¹⁰ Secondly, and more pragmatically, he also believes that keeping the two distinct in theory is crucial to having spiritual care supported by medical staff who view religion and religious workers with suspicion. Maintaining this stance is particularly indispensable to encourage employment of chaplains in secular spaces.¹¹¹ In Taniyama's diagram of spiritual care we see how the patient's relationship with something "transcendent," such as gods or ancestors, comes last in importance. In other words, while religious care can sometimes be a part of spiritual care, the primary goals of spiritual care are to help patients in their social relationships with others and their inner or imagined selves.

Although figures like Kubotera and Taniyama were careful to distinguish between religious and spiritual care, other figures in Japan's hospice care movement have tried to argue

¹⁰⁹ "Supirichuaru kea o kō kangaeru: Supirichuaru kea to shūkyōteki kea," *Kanwa kea* 19, no. 1 (2009): 28.

¹¹⁰ Personal communication, May 9, 2013.

¹¹¹ Taniyama, Panel Discussion, Japan Association for Buddhist Nursing and Vihāra Studies Annual Conference, Kanazawa, August 29, 2015.

more forthrightly for the place of religion in clinical practice. One such Buddhist scholar is Ōshita Daien. Ōshita, an abbot of the Shingon temple Senkōji temple in Gifu prefecture who studied on Mt. Koya and also in Sri Lanka, serves on the board of the Japan Society of Spiritual Care. Ōshita emphasizes that spiritual care should be practiced in society more broadly and not just within the context of the hospice.¹¹² Ōshita also views spiritual pain as predicated on a person's spiritual or religious nature. In other words, spiritual pain arises from a "religious mental state" within the person.¹¹³ According to Ōshita, Japanese spirituality looks something like this:

¹¹² For example, Ōshita views spiritual care and *kokoro* care as analogous. He also seeks to move spiritual pain back into the mainstream of *kokoro* care and expand its scope to include society at large. Uchimoto Koyu, "Supirichuaru kea no shosō (2): Ōshita riron o megutte," *Momoyama Gakuin Daigaku shakaigaku ronshū* 45, no. 1 (2011): 85.

¹¹³ Uchimoto, "Supirichuaru kea no shosō (2)," 100.

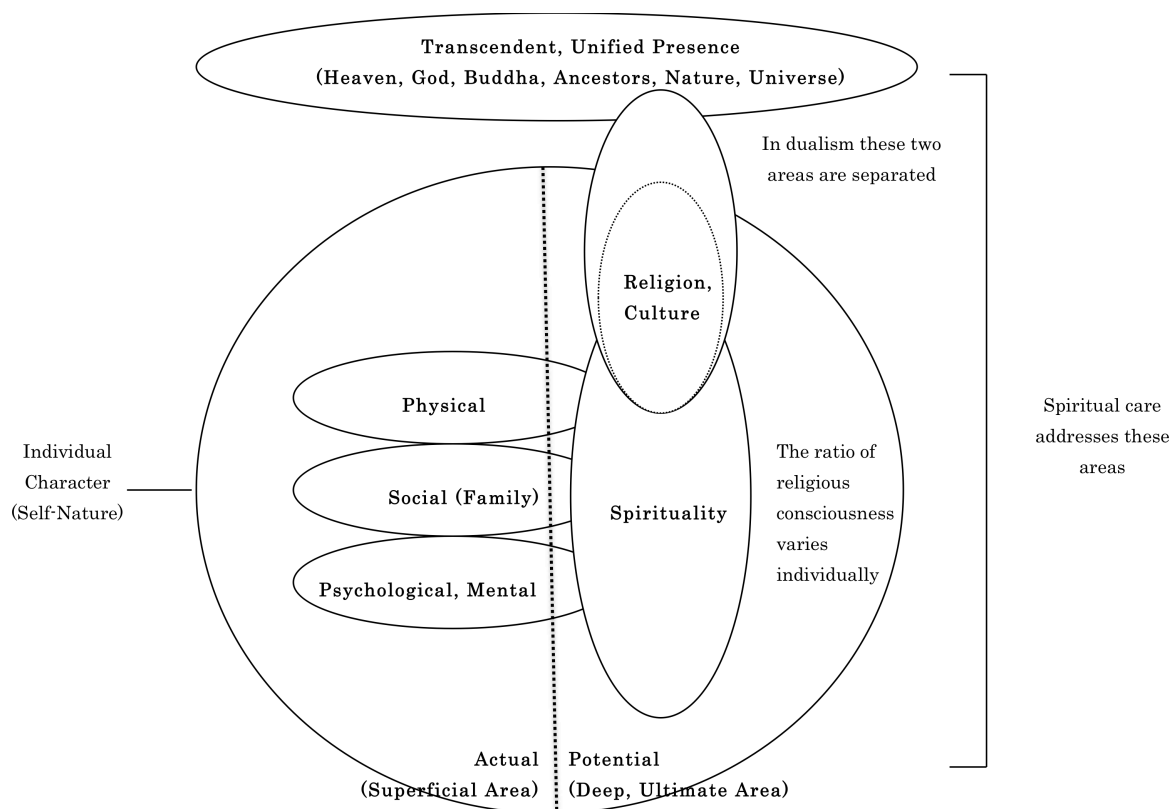


Figure 6. Conceptual Diagram of Spirituality and Spiritual Care¹¹⁴

As this complicated diagram shows, Ōshita sees spirituality to be a dimension of personhood that integrates the physical, social, and psychological aspects of being and can also overlap with a belief in something transcendent. In his view, spirituality is something that integrates the self and forms the basis for a religious consciousness. As for offering religious care to non-religious patients, unlike Kubotera and Taniyama who are more cautious on this point, Ōshita sees religious care as a distinct but also integral component of spiritual care.¹¹⁵ He explains: “I think

¹¹⁴ Ōshita Daien, *Iyashi iyasareru supirichuaru kea: Iryō, fukushi, kyōiku ni ikasu bukkyō no kokoro* (Tokyo: Igakuin, 2005), 23.

¹¹⁵ Ōshita Daien, “Shūkyō to supirichuaru kea: Bukkyō kara supirichuariti no kaitei o himotoku,” in *Taiwa, komyunikeshon kara manabu supirichuaru kea: Kotoba to monogatari no jissen*, Tanida Noritoshi, Ōshita Daien, Itō Takaaki eds. (Tokyo: Shindan to Chiryōsha, 2011), 13.

that instead of trying to force a separation between religious care and general spiritual care, it is much more practical in the clinical setting to view religious care as included in the larger area of spiritual care.”¹¹⁶

Ōshita’s view of spirituality is quite similar to one diagrammed by Takagi Yoshiko, a Catholic sister who serves at the Grief Care Center at Sophia University as well as one drawn by Yamazaki Fumio, the doctor introduced at the very beginning of this chapter.

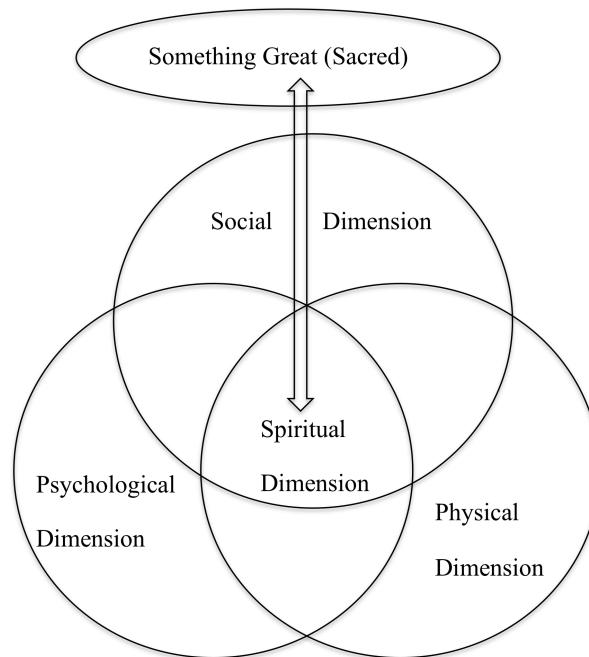


Figure 7. The Relationship Between Spirituality and Something Great (Sacred) (Takagi)¹¹⁷

¹¹⁶ Ibid., 15.

¹¹⁷ Takagi Yoshiko, “Genba kara mita pasutoraru kea to supirichuaru kea, gurīfu kea,” in *Kōza supirichuarugaku dai 1kan*, Kamata Toji et al. eds. (Kanagawa: Beingu Netto, 2014), 66.

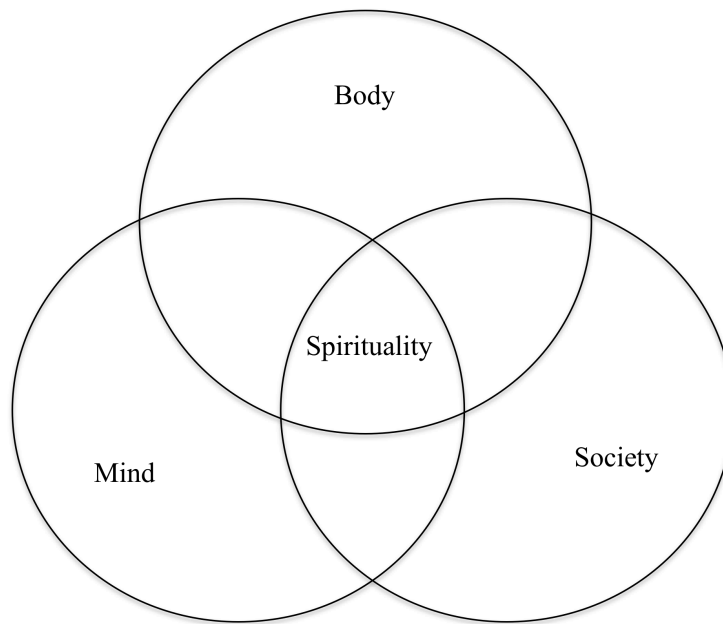


Figure 8. The Location of Spirituality (Yamazaki)¹¹⁸

As these diagrams show, Ōshita, Takagi, and Yamazaki all emphasize that spirituality is the integrating or core element of personhood that also overlaps with the physical and psychosocial dimensions of being.¹¹⁹ Ōshita and Takagi also agree that the spiritual dimension is closely connected to something transcendent or greater than the individual.

Interestingly, Yamazaki's diagram closely resembles Takagi's except without reference to something transcendent. Yamazaki's diagram also echoes the WHO's definition, which defines the "spiritual" as the "integrating component" of the physical, psychological, and social dimensions of persons. Yamazaki later explains through another sequence of diagrams that the challenging circumstances that accompany death crack into these circles to create physical,

¹¹⁸ Yamazaki Fumio, "Ningen sonzai no kōzō kara mita supirichuarupein," *Kanwa kea* 15, no.5 (Sept. 2005): 378.

¹¹⁹ Kawa also talks in terms of self, others, transcendence. Sees spirituality as the foundational "energy" that underlies the physical, psychological, and social dimensions. Kawa Masako, "Waga koku kanwa kea byōtō nyūinchū no shūmatsuki gan kanja no supirituaru pein," *Shiseigaku nenpō* (2005): 48-82.

psychological, or social pain. When these damaging cracks get deeper, they reach the spiritual dimension that is found in the center of the Venn diagram, causing spiritual pain.

Interpreting the Circles: Reconsidering the Spiritual-Religious Binary

These Venn diagrams and other figures are clearly generalizations and their authors intend them to work as heuristic devices to clarify the nature of spirituality. Obviously, a simple diagram is a much easier tool for explaining spiritual care to a fresh-faced nursing student than a nuanced definition of unstable concepts.¹²⁰ Yet at the same time, these “pictures” deserve to be examined, if not quite literally, as illustrative of some of the key issues that drive divergent Japanese understandings of spirituality in the hospice context. As Foucault explains, clinicians have often attempted to use pictures (mostly unsuccessfully) to integrate structures that are “at the same time visible and legible, spatial and verbal.”¹²¹ These diagrams speak to the clinical need to make disease “totalized at last in a motionless, simultaneous picture.”¹²² Clinicians also follow an impulse “to see, to isolate fissures, to recognize those that are identical and those that are different, to regroup them, to classify them by species or families.”¹²³

In the pages below, I will attempt to summarize what we can learn from these classificatory impulses. First, I will discuss the different ways hospice workers conceptualize the

¹²⁰ In 2008, a survey of first year nursing students showed that only 23% were familiar with the word “spirituality” and 70% stated that they did not know what it meant. Hongō Kumiko, “Kango no naka no supirichuaru kea o dono yō ni kyōiku suru ka: Kyōiku genba de no genjyō to kadai,” in *Supirichuaru kea no jitsugen ni mukete: ‘Dai 18kai Nihon Rinshō Gakkai Taikai’ no torikumi*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku Shuppankai, 2013), 91.

¹²¹ *Birth of the Clinic*, 112.

¹²² *Ibid.*, 9.

¹²³ *Ibid.*, 89. For an even more detailed analysis of the particularities of each of the positions taken by various hospice practitioners over definitions of spirituality and models of spiritual care in Japan, see Uchimoto Kōyū, “Supirichuaru kea no gengeronteki tenkai” (PhD Diss., Momoyama Gakuin Daigaku, 2014).

relationship between spirituality and religion. Second, I will critically examine the claim by some hospice practitioners that spiritual care and religious care should be viewed as distinct. Finally, I will show how these “circles” are part of a larger global and trans-denominational conversation in which the concept of spirituality is helping negotiate the acceptable boundaries of religion in medicine.

The first way in which these “circles” differ is the extent to which they see spirituality as linked to religion. For example, before the advent of hospice care, it is clear that, in D.T. Suzuki’s mind, *reisei* was closely linked to religion. Likewise, Shimazono describes the “new spiritual world” movement as an extension, or a postmodern form, of religion. In the hospice, especially prior to 1995, Kashiwagi described spiritual care in more or less religious terms with a preference for a translation of “spirituality” as *tamashii*. Kippes also shared Kashiwagi’s reliance on Saunders’ and the WHO’s explication of total pain but drew more attention the spirit (*rei*), which he described as lying at the core of spiritual needs (*supirichuaru nēezu*). Beginning primarily with Kubotera and Taniyama, however, the existential and religious angst that was awakened in those who were facing dire situations was expressed through the English-loan word of “*supirichuariti*.” As a Christian minister, Kubotera often drew on theological language to explain spiritual pain, but indicated that in practice, spiritual and religious care were to be kept separate. Taniyama, a Buddhist, also played down the role of religion. According to Taniyama, religious care should never be the primary response to spiritual pain, but simply one resource that could be called upon in the rare occasions that it was needed. In contrast to Kubotera and Taniyama who cautioned against conflating religious care and spiritual care, others, such as Ōshita and Takagi, articulated a vision for spiritual care that more openly acknowledged the importance of religious care as part of supporting the patient’s search for something

“transcendent” or “sacred.” Meanwhile, Murata’s view of spiritual care does not preclude religious care but plays down its significance by focusing on how spiritual pain is expressed—an approach that appeals to the vast majority of non-religious hospice workers who are drawn to its clinical applicability.

What is at stake in these interpretations is the question of how spirituality differs from religion. As Horie Norichika points out, Western notions of “spiritual” and “spirituality” tend to be far more religious than in Japan where the transliteration of “spiritual” and “spirituality” into Japanese *katakana* created a kind of *tabula rasa* in which their associations with the supernatural or religion were masked.¹²⁴ When Buddhist scholars like D.T. Suzuki, spiritual counselors like Ehara Hiroyuki, and even hospice pioneers like Kashiwagi Tetsuo initially translated “spirituality” using Chinese characters like *reisei*, this word was more likely to be associated with the supernatural. But as a term like *reisei* became less palatable in hospice settings due a growing negative image of religion in Japanese society, it was eventually replaced by *supirichuaru* and *supirichuariti*, which were free of the supernatural and religious nuances present in *reisei*. As Horie notes: “The katakana words for ‘spiritual/spirituality’ function as signs of security in a social climate that considers that religion is dangerous and should be excluded to maintain the social order. Thus, the use of the terms ‘spiritual/spirituality’ enable people to hide and keep their intrinsic religiosity by positioning themselves closer to secularism.”¹²⁵ This positioning was of vital importance after 1995 for Japanese hospital chaplains who sought to promote spiritual care in the hospice. In a climate where religious groups were coming under closer public scrutiny, the idea that religious workers in the hospice were not providing religious care, but spiritual care, was a key distinction that made their work possible in medical spaces.

¹²⁴ Horie, “Spirituality and the Spiritual,” 2.

¹²⁵ Ibid., 11.

However, this boundary making function of the term spirituality also made spiritual care ambiguous. As Tsuchiya Hiroshi suggests, spirituality in Japan functions as something like a “working hypothesis” (*sagyō kasetsu* 作業仮説) for something that is more than just religious.¹²⁶ At times, spirituality in Japan seems to be defined in relation to religion, at other times, it seems to have nothing to do with it at all. More practically, this ambiguity also prevents hospice workers from seeing how spiritual care is different from the work of a clinical psychologist. For example, when I accompanied a Buddhist chaplain who gave a lecture on spiritual care at a large hospital in Kyoto, he stressed to the doctors and nurses in attendance that his work was much broader than religious care. But after the lecture, a hospital worker queried: “If it’s not explicitly religious, then how does the chaplain’s role differ from that of a clinical psychologist?” Since Japan lacks a tradition of pastoral or spiritual care, psychologists have traditionally addressed the types of wider existential questions that chaplains usually address in the West. From this hospital worker’s perspective, if the chaplain’s role was not primarily religious, it was unclear how psychological and spiritual care could be distinguishable in practice.¹²⁷ In a similar vein, Sakai Yūen, a Buddhist counselor, has raised questions about Kubotera’s differentiation between religious, psychological and spiritual pain. If spiritual pain is not necessarily religious or even existential pain, how can one meaningfully distinguish between psychological and spiritual pain?¹²⁸

Some Japanese hospice workers and scholars have also suggested that the distancing of religion from models of spiritual care also amounts to a secularization of spiritual care that not

¹²⁶ “Sagyō kasetsu to shite no ‘supirichuariti’ no kanōsei to genkai,” *Shūkyō kenkyū* 84, no. 2 (2010): 201-224.

¹²⁷ Uemura Kenjiro, “Seishin, shinriteki pein to sono kea oyobi supirichuaru pein to sono kea,” *Seitan rinri kenkyū* 7 (2013): 12-28.

¹²⁸ Sakai Yūen, “Tamashii no iyashi to inochi no kongensei: Supirichuaru kea no ayumi o tōshite,” *Nanzan shūkyō bunka kenkyūjo kenkyūjohō* 19 (2009): 52-66.

only undermines its ethos and but also demands chaplains to conduct spiritual care in a way that is ultimately untenable in practice. For instance, religious scholar Andō Yasunori has looked at the Japanese hospice setting and sees spirituality as a kind of defanged religion that has missed an opportunity to challenge the medical way of doing things. While he agrees that it is necessary for religious workers to bracket their personal beliefs when dealing with patients, by distancing themselves from religion, he cautions that spiritual care has become overly influenced by the medical environment and professionalized into just one discipline within it. Andō worries that these pressures have also turned the “spiritual” into treatable “mental” issues. In his view, spiritual care was originally supposed to challenge the traditional medical model of “cure” with an emphasis on “care”—instead, he fears that spiritual care is in danger of becoming absorbed by the very clinical gaze that it was supposed to hold accountable.¹²⁹

In a similar vein, the Fukaya Mie, a scholar of social work, and Shibata Minoru, a Christian hospital chaplain, have also argued that trying to separate spiritual care and religious care is untenable in practice.¹³⁰ Based on an in-depth interview study with ten Christian chaplains in Japan, Fukuya and Shibata discovered that in practice, these chaplains were rarely able to distinguish between spiritual care and religious care during their interactions with patients. They suggested that the call for bracketing of religious care in the hospice setting ignores the complex tension chaplains must navigate. On one hand, all chaplains are committed to refraining proselytizing patients. On the other hand, all chaplains believed that religious beliefs invariably informed their work.

¹²⁹ “Seishin bunseki to supirichuariti,” 382; “Ekkyō suru supirichuariti: Shoryōiki ni okeru sono rikai no hirake e mukete,” *Shūkyō kenkyū* 80, no.2 (2006): 73-92; “Gendai iryō bunka ni okeru supirichuariti no isō: Supirichuariti no iryōka o hihan shinagara,” in *Bunka to reisei*, ed. Kashio Naoki, 59-81 (Tokyo: Keiō Gijyuku Daigaku Shuppan, 2012).

¹³⁰ Fukaya Mie and Shibata Minoru, “Supirichuaru kea to enjōsha no shūkyōsei ni tsuite no jissōteki kenkyū,” *Meiji gakuin daigaku shakaigakubu fuzoku kenkyūjyo nenpō* 45 (2012): 43-57.

Finally, the various models of spiritual care outlined in this chapter also demonstrate how Japanese discourse on spiritual care is part of a global and trans-denominational conversation. For example, many of the leaders who pioneered spiritual care in Japan travelled to Europe and the United States to receive training. Kashiwagi was clearly influenced by Cicely Saunders during his travels to Britain, Kippes brought a German Catholic perspective to bear on the subject, and Kubotera received theological training in the United States. But it is also important to note that this is not just a one-way conversation. For example, Murata's definition of spiritual pain is contributing to conversations on spiritual pain in North America as well.¹³¹ Naturally, as concepts travel across linguistic and cultural borders, some things become lost and some new things are produced. In the case of spiritual care, differences certainly abound but what is most surprising is the extent to which the discourse on spiritual care both in and outside Japan are similar. For one, despite many attempts to provide a native Japanese word for the term "spiritual," ultimately, alternative terms have been abandoned in favor of the English loan word—a decision which closely links the practice of spiritual care in Japan to the ways it is practiced and understood in English speaking countries. The discourse on spirituality in Japan also continues to adhere to the four-part understanding of personhood laid out by Saunders and ensconced in the WHO definition of palliative care. Key to this adherence is the pioneering role played by Christian hospice workers and chaplains. For instance, Kashiwagi, Kippes, and Kubotera held Christian religious convictions similar to Saunders' and their division of persons into mind, body, and spirit represented familiar theological ground.

Buddhist hospice workers, on the other hand, certainly had reason to challenge these understandings. As Taniyama and other Buddhist scholars have noted, a correct Buddhist

¹³¹ See for example, Marvin D. Delgado-Guay et al., "Spirituality, Religiosity, and Spiritual Pain in Advanced Cancer Patients," *Journal of Pain and Symptom Management* 41, no. 6 (June 2011): 986-994.

approach to spiritual care seeks to illustrate that metaphysical distinctions between the body, mind, society, and spirit are purely conventional.¹³² Accordingly, one might expect Buddhists involved in hospice care to put forward a theory of spirituality based on illuminating the nature of self, of suffering, and its alleviation. However, although more explicitly Buddhist conceptions of spiritual care are sometimes addressed to Buddhist audiences, these views have yet to be reflected in a significant way in Japanese medical literature, which for the most part has inherited the conceptions of spiritual pain outlined by Christian hospice pioneers. This also raises the question of why understandings of spirituality in Japan do not necessarily break down more clearly along religious lines. For example, Kubotera (Christian) and Taniyama (Buddhist) are in agreement that spiritual pain should be treated differently from “religious pain” while Takagi (Christian) and Ōshita (Buddhist) seem to agree that they cannot be separated. Possible reasons for this ecumenical spirit may lay in the difficulties both Christian and Buddhist groups face in convincing secular hospice workers of the value of spiritual care. In the context of overall declining religiosity within Japan, rather than promoting spiritual care from a particular religious perspective, the proponents of spiritual care have sought legitimation for their work by banding together and promoting an ecumenical vision of spiritual care.

As this comparison of the many different “circles” that describe spirituality and spiritual care demonstrate, most of the authors discussed above agree that spirituality describes something distinct and discrete, that “functions” in the face of a crisis. All the authors also depict spirituality as representing one of the core dimensions of personhood. However, beyond agreeing that spirituality is very *real*, there is a diverse range of interpretations on the relationship between religion and patient spirituality. However, this contestation itself speaks to the important

¹³² Taniyama Yōzo ed., *Bukkyō to supirichuaru kea* (Osaka: Tōhō Shuppan, 2008).

boundary making function that spirituality plays in the hospice setting. Although spirituality is depicted as a dimension of *being* that is present in every patient, in as much the term functions as a floating signifier, the term reveals more about those who use it than patients themselves.

Conclusion

In the end, the answer to Yamazaki's initial question, "What is spirituality?" represents a complicated definitional struggle over the appropriate roles that religion, humanistic psychology, and medicine should play in care for the dying in Japan. When D.T. Suzuki initiated the discourse on spirituality in postwar Japan, it began as an effort to redefine Buddhism for the modern era. Suzuki's observation that Japanese had a "shallow" understanding of religion informed his goal of introducing the word *reisei* to his readers as a true form of religious consciousness. He also helped articulate this in individualistic terms as something that lies deep within persons, and as a faculty that becomes "awakened." To Suzuki, spirituality was thus both an alternative to religion but also intimately tied to it. In contrast, the "new spiritual world" movement that began in Japan during the 1970s was couched in rhetoric of growing dissatisfaction with both traditional religion and secular materialism. The rise in this discourse was also closely aligned to the rise of self-help groups and a therapy culture in both Japan and the West during the 1980s, along with growing attention to transpersonal psychology, death education, holistic medicine, and hospice care.

The concept of spirituality in clinical practice drew from these broader cultural currents but also articulated spirituality as a discrete aspect of personhood, capable of "pain," and one of four dimensions of personhood. In Europe, Cicely Saunders played a key role in helping ensconce the spiritual dimension within palliative care through her introduction of the concept of

“total pain,” and her four-part definition of personhood was later mirrored in the WHO’s definition of palliative care as well. In Japan, although disagreement remains as to what exactly the spiritual dimension represents, the concept of patient spirituality has provided Japanese chaplains with a way to negotiate the ambivalent nature of their work: religious experts who are also called upon to minister to patients in non-religious ways.

The global view that spirituality represents a discrete dimension of personhood also raises the question of whether the differences between humanistic psychotherapy and non-religious form of spiritual care are—for the most part—negligible. In other words, since Saunders drew her theory of spiritual care from psychotherapists like Frankl to begin with, one lingering question is whether it could not simply be relabeled in those original terms. In France for instance, Tanguy Châtel has suggested that the spiritual dimension of care could be simply stripped of its religious associations and replaced with the “existential dimension” (*dimension existentielle*).¹³³ If spiritual pain is understood as not only consisting of religious questions, but questions pertaining to a range of existential issues, he suggests it could just as well be labeled as “existential” pain. As for the spiritual dimension, Châtel suggests that this could be understood as the broader concept that underlies and remains at the center of the other four components of what it means to be human—the *composante physique, psychologique, sociale, and existentielle*. By reverting to the word “existential,” Châtel thus returns full circle to the terminology originally used by Frankl in his description of the deep suffering that Saunders initially chose to label as “spiritual pain.” In Japan, however, although some hospice workers have occasionally used the term “existential pain” (*jitsuzonteki itami* 実存的痛み) interchangeably with “spiritual

¹³³ Tanguy Châtel, *Vivants jusqu’à la mort: Accompagner la souffrance spirituelle en fin de vie* (Paris: Albain Michel, 2013).

pain,” the term “spiritual” remains far more popular, even when its meaning is less clear.¹³⁴

The general tenor of global clinical discourse on spirituality also exhibits a tendency towards reifying the idea of spirituality. This is primarily because many academics or clinicians who participate in this discourse on spirituality, are heavily invested in the concept. This in turn can lead to situations where spirituality is detected in places where the term is not being invoked.¹³⁵ The drawback of this approach that takes the concept of spirituality as a universal category is its failure to take into account its dynamic discursive or boundary marking function, which only makes sense in their particular clinical or academic contexts.¹³⁶ Perhaps more importantly, the tendency towards the reification of spirituality also undermines the ethos of spiritual care. Although all Japanese hospice workers stress the importance of maintaining a holistic approach to caring for patients, the “search for spirituality” that takes place in diagrams and definitional debates is also an exercise in dissection. In this way, the study of spiritual care at times seems at odd with Saunders’ interest in the concept of total pain in the first place: to treat the person as a whole person.¹³⁷

If the debates over the definition of spirituality in hospice settings seem confusing, it is because they are. The “circles” that hospice workers and scholars have resorted to drawing attest

¹³⁴ For a study of “existential pain” in Japan see Morita, et al., “Existential Concerns of Terminally Ill Cancer Patients Receiving Specialized Palliative Care in Japan,” *Support Care Cancer* 12 (2004): 137-40.

¹³⁵ Horie, “Spirituality and the Spiritual.”

¹³⁶ Nishihira Tadashi, “Supirichuariti saikō: Rubi to shite no ‘supirichuariti’,” in *Supirichuariti no shinrigaku: Kokoro no jidai no gakumon o motomete*, Andō Osamu and Yuasa Yasuo eds. (Osaka: Seseragi Shuppan, 2007), 85.

¹³⁷ This imperative to treat the “whole” person is also found in the writings of the influential Swiss physician Paul Tournier, who authored the book *Médecine de la Personne* (1940). Tournier later relates a story of someone who asked him whether his idea of *médecine de la personne* would be better expressed as *médecine pneumo-psychosomatique*, an expression that would add “spiritual” to the growing medical interest in viewing patients as “psychosomatic” beings. However, Tournier voiced his opposition to this idea, claiming that the term “psychosomatic” was bad enough. Dividing patients even further into three dimensions, the “spiritual, psychological, and somatic,” went against the whole point of his endeavor to treat those under his care as *whole* beings. Paul Tournier, *Jinsei o kaerumono: Tournier no sekai*, trans. Yamaguchi Minoru (Tokyo: Yorudansha, 1987), 68.

to the difficulties many hospice care practitioners face when asked to define spirituality. This chapter has sought to show some of the stakes that are involved in these definitional debates; how these conversations are both part of a global conversation and simultaneously being “invented” in Japanese clinical settings; and also how spirituality tends to be reified in clinical settings into a dimension of being. However, it has yet to touch on the most important subject: how these views translate into actual practice of spiritual care. In the next two chapters we will leave the Venn diagrams behind and finally enter the hospice ward to consider spiritual care in Japan from the inside out. What does spiritual care look like? Who does it? What do patients think about it? Perhaps the answers to these questions may provide more clarity on Yamazaki’s question about what makes spiritual care “spiritual.”

Chapter Four

Getting to the Heart: Spiritual Care in Practice

As we enter the hospice outpatient examination room, I notice it is devoid of medical machines. The doctor sits down before the computer, picks up the file lying on the desk, and reads through the patient's referral letter. I sit on a stool as far back in the room as I can. A corridor that runs along the back of the room connects the examination room to others. By leaning back and peering to my left, I can see the nurse preparing to listen and take notes in the adjoining room. After the doctor finishes checking the patient's X-rays, he tells the nurse: "Please show them in."

The door slides open and the patient's wife and daughter enter the room. For some reason I expect the patient to enter as well, but his absence immediately makes sense: the patient, in his seventies, is bedridden with ureteral cancer. The doctor first confirms the wife and daughter's relationship with the patient and types this into the computer. He then pauses, makes eye contact, and introduces himself. He does not bother to introduce me but when they glance in my direction I give a slight nod. He asks them to describe the patient's condition and the kind of pain he is experiencing. They explain how his urine has started to show blood and how his body often shakes. He has no bowel movements and his urine is being artificially drained from his kidneys. He is not coughing. He is receiving fluids intravenously. He is aware of his condition. The doctor types all of this into the computer.

The doctor then explains that the hospice has two kinds of rooms: one type is free of charge but a little small, the other is larger but at an additional price. The wife and daughter interrupt him:

“Either one is fine... please, whichever is available sooner, even if it costs.”

“Ok, I will contact you again when a room becomes available.”

The wife rises up from her stool a few inches as if to depart but her daughter squeezes in another question. The wife sits back down. “Can you give us an estimate? When we look at his condition, we feel he doesn’t have that much time left and if possible, we would like to have him come while he is still conscious.” The slight tremor and sense of urgency that had been in the daughter’s voice throughout the interview was growing stronger.

“Well, let me see. It will probably take one to two weeks.”

“If he can come even one day earlier...”

The daughter chokes on her words and starts to cry. The doctor sort of cuts her off.

“I understand. We will do our best.”

After the family leaves, the nurse sighs, “It’s looking grave.”

In Japanese, the word *kibishii* 厳しい, meaning “grave” or “severe,” is a common euphemism for “close to death.” Doctors gingerly explain to families that the patient’s condition is becoming *kibishii* or that the amount of time left is *kibishii*. Staff might even refer to certain patients as simply a “*kibishii* patient.” Yet the atmosphere of the hospice is far from just *kibishii*. Rather, many patients and family describe the hospice as a place where they feel “safe” (*anshin* 安心), “relieved” (*hotto* ホッと), “at ease” (*raku* 楽), and even “healed” (*iyasareta* 癒された). This is because entering the hospice is akin to reaching the summit of a mountain. Before entering hospice care, patients are faced with an uncertain future and a plethora of decisions to make. How much longer should they continue chemotherapy? Should they switch to a new treatment or medication? Get a second opinion? Should they go home or stay in the hospital?

When curative treatment options have been exhausted, how long will they be able to stay in the hospital? Where will they go next? The anxiety that accompanies these decisions takes its toll and a patient's family can become quite desperate. In addition to the emotional pain of losing a loved one, family members are taxed physically as they juggle hospital appointments, work, and their own family's needs.

It is no wonder many patients and families feel great relief when they enter the hospice. Although decisions still remain, the goal is much clearer. Doctors can forgo curative treatments and focus exclusively on alleviating the patient's physical discomfort, usually quite successfully. As one hospice patient whom I will call Higashimoto-san explained to me:

The specialty at the hospital is treatment. That is their specialty. Here, their specialty is palliative care. [In the hospital] I had horrible bedsores and couldn't sleep at night. My *kokoro* was not calm. I came here and received different treatments and now almost all the pain is gone. With the pain gone, I am finally able to attempt to do more things. While I had the pain, to be honest, I had no desire to do anything.... Now I am [finally] able to become forward-looking (*maemuki* 前向き). I have no complaints.

One of the hallmarks of hospice care in Japan is helping dying patients achieve a calm *kokoro*—including through the practice of spiritual care.¹ In the previous chapter I outlined some of the ways spiritual care in Japan has been defined in relation to ideas about the “spiritual” dimension of personhood, conceived as the locus of “spiritual pain.” In particular, I showed how these concepts in Japanese clinical literature play the important function of marking the acceptable boundaries of religion in care for the dying and also of legitimizing spiritual care by demonstrating a reified “spiritual dimension” in patients as part of what it means to be human. But in practice, the *kokoro* of hospice patients tends to elide the neat circles and diagrams that

¹ As noted in Chapter Two, the religious dimensions of hospice care were often featured in the news media with reference to their ability to provide “*kokoro* care” as well as “*kokoro* support” and “*kokoro* medicine.” *Asahi Shimbun*, “Makki kanja o dakishimeru,” May 28, 1985; *Asahi Shimbun*, “Bukkyō hosupisu no jitsugen o,” October 27, 1986.

delineate the spiritual realm from the physical, psychological, and social dimensions of care in Japanese clinical literature on care of the dying. This chapter, based on fieldwork in Japanese hospices, will therefore set about challenging the “spiritual dimension” of hospice care as a theoretically discrete realm and instead show just how permeable those lines become in clinical practice.

In order to challenge the “spiritual dimension,” this chapter will first draw on ethnographic fieldwork to reimagine what constitutes the core of spiritual care in Japan. Spiritual care in Western settings generally refers to providing patients with religious or existential support as patients deal with deep questions about the meaning and purpose of life, guilt and regrets, feeling of isolation, or concerns about the afterlife.² While it is true that definitions of spiritual care in Japan are also clustered around the idea of helping patients “search for meaning,” my approach in this chapter is not to use these ideas to stake out my own predetermined definition of spiritual care and carry out a comparative analysis by searching for examples of it in the Japanese setting. Instead, I will examine the range of meanings and practices Japanese hospice workers attach to the concept of spiritual care in their daily clinical work. In this way I hope to show that spiritual care in practice is much more diffuse than the reified theoretical conceptualizations of “spiritual care” that appear in the Japanese professional literature I outlined in the previous chapter. I will also focus on some of the concrete *ways* spiritual care is offered to Japanese patients, including what I term vocal care, resonating care, and supportive care.

² Pulchaski, “Restorative Medicine.” Religious support typically refers to those activities and interactions with patients that are openly framed in religious language, including religious services, prayer, sutra recitation (in a Buddhist context), or open-ended conversation on religious topics between patients and chaplains. Existential support on the other hand is not limited to religious frames and is generally concentrated on helping the patient in their “search for meaning.”

Based on interviews with dying patients, their physicians, and their caretakers and my own observations of hospice settings, I suggest the particular importance of “supportive care” in Japan, by which I mean a type of spiritual care that goes beyond helping patients vocalize spiritual concerns or directly addressing their anxieties through counseling, religious support or being a sympathetic presence. Instead, much of spiritual care is also conducted “supportively” in the margins of daily care, for example, through special hospice events or even in the course of prosaic activities. This approach elicits less resistance by Japanese patients than do models of spiritual care that borrow from a Western emphasis on religious or existential care found in the tradition of pastoral counseling. In Japan, chaplains at the bedside are quick to recognize that the cultural foundation for offering prayer, reciting sutras, conducting religious rites, or candid discussion of religion and existential issues with dying patients who have never even heard of the word “spiritual care,” or who generally view religious professionals with suspicion, is weak. In this way, the Japanese case also serves as an instructive example for comparative understandings of how hospice chaplains in different cultural settings go about providing spiritual care to non-religious patients.

This is not to say that supportive care is less important in Western contexts. As one American chaplain remarked to me, “That sounds a lot like what we do!” Winifred Sullivan’s recent work on chaplaincy in the North America also suggests that chaplaincy is essentially a “ministry of presence.”³ However, in the pages below I suggest that the degree to which supportive care is utilized in Japan, as well as the reasons for its use, are distinct from North American or European contexts where spiritual care is a relatively familiar term and patients

³ Sullivan, *Ministry of Presence*.

have clearer expectations about the kinds of services chaplains are able to provide.⁴ Thus my ethnographic intervention is not directed so much against the way spiritual care is understood in Western settings, but rather against a normative strain of academic and clinical Japanese scholarship outlined in the previous chapter that stakes out, defines, and justifies the practice of spiritual care as something distinct from other forms of care. While this makes sense in some cases, it also ignores the important ways that spiritual care is practiced in the margins of many other kinds of care that deal with the more prosaic needs of patients—both in Japan and in other cultural contexts.

In order to contextualize the practice of spiritual care, this chapter will also endeavor to provide a glimpse of a typical day in the Japanese hospice ward. It will introduce how patients are received in the hospice, how care is discussed in staff conferences, what takes place during patient visitation, the events and activities provided for patients, and finally, how patients leave the hospice. Many of these activities are centered on helping to mitigate the patient's physical pain, which is one of the few things hospice staff can actually control. However, these activities also shed light on how patient's spiritual needs are also addressed in the interstices of other forms of care. One of the key maxims of hospice care in Japan is to help the patient die in a way that reflects who they are (*jibunrashiku shinu* 自分らしく死ぬ). In order to help patients achieve this, hospice workers use a range of strategies to cultivate intimacy and trust with patients. These activities help form the basis of spiritual care. Paying attention to the rhythms of daily hospice care also helps us see the emotional labor that is involved in spiritual care. As

⁴ The degree to which religious care is provided to patients is also arguably higher in North America. For example, Koenig, King, and Carson argue that in order to avoid confusion with psychological care, definitions of patient spirituality should be focused on those pursuing a “religious way of life” or the “transcendent.” Harold G. Koenig, Dana E. King, and Verna Benner Carson, *Handbook of Religion and Health* (New York: Oxford University Press, 2012), 46-47. In Japan by contrast, the “transcendent” plays a very minor role in wider practice of spiritual care.

hospice workers interact with a wide variety of patients throughout the busy workday, they are required to manage their emotions in such a way that patients will feel valued and supported.

Finally, this chapter will also consider the broader implications of the practice of spiritual care. Namely, I will examine how the mundane and tactile ways in which spiritual care is practiced help to complicate the search for a definition of spiritual care that is distinct from the physical, psychological, and social dimensions of hospice care as outlined in the World Health Organization's definition of palliative care. I also show how the way practitioners practice spiritual care often reflects a concern for Japanese notions of *kokoro*, in which the realms of the physical, psychological, social, and spiritual are not so easily disentangled.⁵ In the end, I suggest that a closer, especially ethnographic, study of spiritual care provides an opportunity to examine how religion in contemporary Japan is both shaping and being shaped by medical spaces and practices as hospice workers try to get to the heart, or *kokoro*, of spiritual care.

What is Spiritual Care?

In this section I will examine what spiritual care looks like on the ground. I will begin by suggesting that determining what counts as spiritual care is less about the “what” and more about the “how.” I will also introduce some of the ways religious support is provided to Japanese hospice patients and discuss my own ethnographic findings, which was corroborated by chaplains, to suggest that overall, religious support plays only a very minor role in most hospices.

⁵ These entanglements also help problematize one dimensional understandings of how the practice of spiritual care can be “secular” or “post-secular” in Japanese society, and reveals the ways in which the spiritual care movement is being appropriated by contemporary religious groups, chaplains, the media, and religious studies scholars to help valorize the role religion can play in Japanese society. For more on how the practice of spiritual care problematizes both theories of secularization and post-secularization in Japan, see Timothy Benedict, “Practicing Spiritual Care in the Japanese Hospice,” forthcoming in *Japanese Journal of Religious Studies* 45, no.1 (2018).

This will help us see in subsequent sections how hospice workers in the ward discuss and practice spiritual care as something that goes beyond caring for the religious or existential concerns of patients. Rather the actual practice of spiritual care is viewed by hospice workers as deeply imbricated in many other types of care for the dying.

According to former chaplain Konishi Tatsuya, because the practice of spiritual care takes so many forms, an argument can be made that there should not be just one definition of what it is.⁶ Andō Yasunori, a scholar of Japanese religion, makes a similar point by suggesting that definitions of spiritual care should not focus on what is being done, but on the relationship between the medical worker and the patient:

In other words, as I said before, spiritual care isn't something that you can say, "This is it!" and put into a manual. Rather, the medical worker and patient encounter each other as fellow human beings, and within each specific interchange, a kind of resonance (*kyōmei* 共鳴) arises between them. When a "space" is formed where spiritual events (things that are too deep in meaning to be easily dismissed as happenstance) can easily occur or not be hindered, the regular care toward the patient "becomes spiritual" and "takes on the meaning of spiritual care." In this way, spiritual care is something that is generated in each situation.⁷

Andō thus posits that anything can be labeled spiritual care if it is done in the right spirit. A veteran doctor at a Christian hospice also echoed this view:

I think you can define spiritual pain, but spiritual care cannot be defined. So, for instance, you could say that any kind of care that makes the patient feel valued (*taisetsu* 大切) is spiritual care. For example, let's say a patient wants to eat a watermelon in the middle of the winter. You search through various stores and bring it to the patient to eat. In a sense, I think this too is spiritual care.⁸

⁶ Konishi Tatsuya, "Chapuren to iu senmonshoku no tachiba kara supirichuaru kea o kangaeru," in *Supirichuaru kea no jitsugen ni mukete: 'Dai 18kai Nihon Rinshō Gakkai Taikai' no torikumi*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku shuppankai, 2013), 65.

⁷ Andō, "'Supirichuariti' gainen no saikō," 19.

⁸ Personal interview, January 22, 2015.

From this perspective, spiritual care is ultimately a matter of the heart. It also becomes a form of care that is more or less intuitive and can be provided by all the hospice staff. Staff members are simply asked to value the patient. One nurse expressed a similar sentiment:

In the past we used an interview guide [for assessing spiritual pain]... but I don't think just listening [to patients answer questions] in a certain order is spiritual care. It's more about the way you carry yourself as a caregiver. Just asking [the patient] to talk about their spiritual pain isn't enough for the patient to open up. I think it might be more about saying good morning and providing daily care. These individual things add up to spiritual care. Within this kind of care, you affirm that person's existence so he or she can think, "It's okay for me to live today"—that is when you develop a relationship with patients so they will share things with you naturally.⁹

As this nurse suggests, spiritual care in practice rarely involves addressing one particular need. Rather, spiritual care is something that takes place in the margins of regular care. When practiced effectively, this type of care can also open up opportunities for patients to share even deeper concerns.

These perspectives suggest that spiritual care is less about *what* is being done and more about *how* it is conducted. This stands in contrast with regular medical care, which is largely defined by the content of care. Adjusting a patient's morphine titration or administering a bath is still physical care no matter *how* it is delivered. When asked to define spiritual care, activities such as counseling, praying with, or sitting silently with a patient commonly come to mind and are emphasized in textbooks on the subject. In practice, however, staff emphasize that these activities are not in and of themselves sufficient to be regarded as spiritual care. Rather, various activities that take place in the hospice are imbued with the label of spiritual care by the heart of the caregiver.¹⁰

⁹ Personal interview, February 2, 2015.

¹⁰ In a similar vein, Courtney Bender discusses how volunteers who help cook food for a secular non-profit organization can assign sacred value to the work they perform, where even cutting carrots is

Morning Assembly and Religious Services

The day begins in many hospices with morning assembly (*chōrei* 朝礼). This is an opportunity for the entire hospice staff to come together and affirm their vocational mission. In religious hospices that have a chaplain on hand, the morning assembly often takes a religious form. At Christian hospices for example, the morning assembly may double as a religious service that involves a scripture reading, hymn or song, followed by a short inspirational story or sermon, and prayer. At one Protestant hospice I visited, the doctor opened the workday by sharing a Bible story about how Jesus instructed his disciples to cast their fishing nets on the other side of their boat after failing to catch anything all night. The doctor explained to fellow staff members that sometimes when she was exhausted by her work, she would react poorly to a suggestion from a nurse. However, just as Jesus' suggestion to the disciples resulted in a catch of fish so heavy that it could not be hauled in, so too, this Christian doctor suggested, should staff remain open to being corrected by others. At another Catholic hospice in Kyūshū, the morning assembly began with a hymn or spiritual song but there was no scripture reading or prayer. Instead, every day different staff members took turns sharing a short uplifting story or episode from their personal life before beginning their workday. When the morning assembly doubles as a religious service, patients and families may also be welcome to participate. At one hospice, the service was even broadcast over the public announcement system and made viewable by patients on their TV sets.

At religious hospices, additional services may also be conducted at other times during the day. For instance, the day begins and ends in Buddhist Vihāra hospices with a service called

likened to meditation. Courtney Bender, *Heaven's Kitchen: Living Religion at God's Love We Deliver* (Chicago: University of Chicago Press, 2003), 63.

omairi お参り (lit. visiting).¹¹ Staff and patients enter the Vihāra Hall where they take prayer beads and a small volume of sutra excerpts in hand. They then follow the Vihāra priest in reciting the “Verses of the Serious Vow” (*Jūseige* 重誓偈) in the morning and the “Verses of Praises to the Buddha” (*Sanbutsuge* 讃仏偈) in the afternoon while facing the Buddhist altar at the front of the room. At another, transsectarian Vihāra ward, the *omairi* began by chanting the “Threefold Refuge” (*Sankiemon* 三帰依文) and then the “Heart Sūtra” (*Hannya shingyō* 般若心経) in a hall which housed a seventeenth-century bodhisattva image from Burma.¹² Each recitation takes about ten minutes. During the afternoon *omairi*, one of the Vihāra priests also delivers a short sermon of about ten minutes that is humorous or inspirational.

At one such service I sat next to someone called Minami-san, a quiet elderly woman whose face broke into a hundred wrinkles when she smiled. I held her glasses case while she weakly but accurately chanted in unison with the priest. During his sermon, the Vihāra priest shared a story from his childhood. His parents owned a gas station and his mother was from a temple family. One night while he and his brother were studying for school exams, they heard a clatter on the stairs. His mother had fallen down the stairs and was bleeding profusely. They called an ambulance and on the way to the hospital they kept asking her if she could say her name. The only thing she said to her son before she fell unconscious for ten days was to “value the *nenbutsu* 念仏” (Buddhist prayer). Now, the priest says, when he visits his elderly mother, he recalls all the sacrifices she made for him as he carefully shaves her wrinkled face. When he

¹¹ *Omairi* typically refers to visiting a temple, shrine, or an ancestor’s grave for purposes of worship, prayer, or paying respect.

¹² I was informed that a foreign Buddha image was chosen on purpose to stress the transsectarian nature of the hospice. Furthermore, a bodhisattva image was intentionally chosen over an image of a Buddha. Since the role of bodhisattvas is to take on themselves the sufferings of all beings, a bodhisattva image was viewed as more appropriate in light of the continued sufferings of patients.

does this, he is always touched as he considers how each wrinkle represents a moment of sacrifice and hard work in her life. Minami-san smiled and nodded beside me as she listened to the story. It was a story that she, and her lined face, could appreciate.

Volunteer priests from the local community also help give sermons. On a hot summer day I joined one patient, two doctors, and three nurses while a local priest gave a short talk shortly after the *obon* お盆 festival, which honors the visit of ancestral spirits. He spoke of visiting a parishioner, an old grandmother, who liked to use cucumbers, eggplants, and toothpicks to fashion a miniature horse and cow for display during *obon*. She did this to encourage ancestors to come visit her quickly (horse) and leave slowly (cow). This year, her grandson wanted to participate in this activity and fashioned an animal out of a gourd. The priest humorously pondered what the gourd might represent, such as the rough skin of a wild boar. He used this story to suggest how many young parents have not done a good job explaining old Buddhist traditions to younger generations. He then praised grandmothers and grandfathers—his intended audience—who have made an effort to pass on such important traditions.

Staff attendance at morning assembly and other services varies widely. When the morning assembly occurs before the day shift, staff participation is voluntary. In such cases only a few staff may participate, if any at all. At one Christian hospice with low attendance, the chaplain related to me how he began going to the nurse station to start the day with prayer saying: “If they can’t come to me, I should go to them.” At yet another hospice, assembly was considered part of the workday and staff attendance was required except for those who were attending patients.¹³ Patient attendance also varies. If patients can still walk on their own and are

¹³ However, since many nurses and doctors make checking on the status of their patients a priority in the morning, attending assembly can become an afterthought. But for a few, listening to the organ while

either deeply religious or bored, they might attend. Most often, however, bedridden patients with no strong interest in attending are content to stay in their rooms where they might be still finishing breakfast or dozing.¹⁴

Where Does Religion Fit In?

In general, other than morning assembly or *omairi* type services, religious support plays a very minor role in Japanese hospice care.¹⁵ In fact, even the *omairi* services are framed as a traditional cultural rite that many non-religious Japanese might conduct at home in front of their Buddhist altar. Taniyama Yōzō, who served as a Vihāra priest for three years, states that in his experience, only one out of a hundred patients ever expressed interest in learning more about Buddhism, despite the presence of a Vihāra hall and daily *omairi* services which attracted a fair number of patients.¹⁶ The opening page to a popular textbook on spiritual care also explains, “In the Japanese clinical setting, the majority of patients, family members, and medical workers tend to refuse religious interventions. In fact, you could say that there are hardly any real opportunities to lessen the spiritual pain of patients through religious care.”¹⁷ Likewise, several Christian chaplains I spoke with estimated that approximately eighty to ninety percent of patients

sitting in the chapel or reciting a sutra is seen as an opportunity to collect themselves before rushing into their busy workday.

¹⁴ At Asoka Vihāra Hospital in Kyoto, 38% of 187 patients attended at least one *omairi* service between 2008 and 2011. When I visited in 2012 and 2014, there were rarely more than three patients in attendance. For a detailed breakdown of the patients who attended *omairi* during this period by religious affiliation, see Baba Hiroyasu, Hanaoka Naoki, and Tsukie Noriaki, “Shūmatsu iryō no naka ni okeru jōchū sōryo no yakuwari ni tsuite no kentō,” (paper presented at the Nihon Shi no Rinshō Kenkyūkai, Chiba, Japan, October 2011).

¹⁵ By religious support or care, I refer to those activities and interactions with patients that are openly framed in religious language of particular traditions, including religious services, prayer, sutra recitation, or open-ended conversation on religious topics between patients and chaplains.

¹⁶ Supirichuaru kea jirei kentōshū sakusei gurūpu. ed., *Supirichuaru kea jirei kentōshū: Taiō ni konan o kanjita bamen to sono imi* (Osaka: Japan Hospice Palliative Care Foundation, 2011), 130.

¹⁷ Tamura Keiko, Kawa Masako, Morita Tatsuya eds. *Kango ni ikasu supirichuaru kea no tebiki* (Tokyo: Seikaisha, 2012), 4.

did not or were unable to communicate interest in religious or existential topics while in the hospice.¹⁸ At another hospice affiliated with a Buddhist New Religious group, the Risshō Kōseikai 立正佼成会, a doctor explained, “We thought we needed chaplains on call twenty-four hours a day, 365 days a year, and so we were able to create such a system with everyone’s cooperation. However, after a year or two had passed, we found that there was no demand from anyone to talk with such chaplains.”¹⁹ Ultimately, this hospice chose to discontinue having a full-time chaplain on call for this reason.

There are several explanations for why hospice chaplains have few opportunities to provide religious care in Japan. First, as stated earlier, many patients have only a vague idea of who chaplains are or what their work entails. In some cases even the hospice staff have only a vague idea of the chaplain’s role. One chaplain at a Christian hospital in Tokyo explained how many doctors and nurses hesitated to refer patients to him since they were never quite sure when it was “a job for the chaplain.” In order to encourage familiarity with their work for patients and staff, many chaplains eschew their official title and the foreign sounding word of “chaplain” in favor of more self-explanatory titles such as a “counselor,” the “hospital priest,” or “pastor.”

¹⁸ Personal interview, March 25, 2015; Personal interview, May 5, 2015. On the other hand, while many chaplains explain that only a few patients ever outwardly express interest in religion, family members of patients sometimes felt that patients did receive religious care. For example, a survey of 378 bereaved families indicated that nearly a quarter of patients received some sort of religious care while in a religious hospice. Of those who did *not* receive religious care, the majority explained that this was because the patient had a poor image of religion, was not in need of religious care (44%), or was physically unable to receive such care (38%). For those who did receive care, “more than 80% of the families of patients who received religious care felt that attending a religious service, listening to religious music, a religious atmosphere, and meeting with a pastoral care worker was ‘very useful’ or ‘useful.’ ” This discrepancy may be due to the fact that patient families were much more liberal than chaplains in their understanding of what constitutes religious care. Michiyo Andō et al., “Value of Religious Care for Relief of Psycho-Existential Suffering in Japanese Terminally Ill Cancer Patients: The Perspective of Bereaved Family Members,” *Psycho-Oncology* 19 (2010): 753.

¹⁹ Hayashi Moichiro, “‘True Regard’: Shifting to the Patient’s Standpoint of Suffering in a Buddhist Hospital,” in *Buddhist Care for the Dying and Bereaved*, Jonathan S. Watts and Yoshiharu Tomatsu eds. (Boston: Wisdom Publications, 2012), 63.

When introducing themselves to patients, chaplains also rarely describe their work as providing spiritual care. Although the term “spiritual care” may be used amongst staff and in medical charts, chaplains prefer to explain this aspect of their work to patients and families with a more familiar word, such as caring for the *kokoro* of patients.²⁰

A second reason for the lack of religious care is that many patients are simply not in the hospice long enough to receive such care. In 2000, for example, 92% of patients stayed in hospice for thirty days or more; but by 2015 this number had shrunk to 54%.²¹ What this means for hospice workers is that instead of getting to know a patient over several months, increasingly, hospice staff must acquaint themselves with the patient over a space of weeks. Moreover, since these weeks come at the end of life, many patients arrive in serious condition, making the window of opportunity for communication difficult. Many patients can barely eat, are heavily sedated, or have trouble breathing. In short, with an increase in the number of patients with low alertness or communication abilities, there are simply fewer opportunities to have meaningful conversations with patients.²²

Third, the lack of explicit religious care is also due to the fact that many Japanese remain suspicious of religious professionals. In a 2012 general population survey conducted by the Japan Hospice Palliative Care Foundation (JHPC), more than half of respondents stated that they

²⁰ This included the way I presented my own research to patients as well. Since most patients would have no idea what “spiritual care” meant, I explained that I was conducting research on end of life care for the *kokoro*.

²¹ One reason for this is that as anticancer treatments and drugs have improved, patients can choose to pursue aggressive medical treatment at the end of life without suffering the painful side effects that previously motivated patients to give up treatment earlier. Thus many patients (and especially their families) prefer to extend treatment longer and only enter the hospice after all their medical options have been exhausted or treatment becomes too physically taxing. Igarashi and Miyashita, “Dētā de miru,” 81.

²² This point was driven home in my fieldwork when on many occasions nearly all the patients I visited were sleeping. Or perhaps even more tellingly, over six months of weekly visits to one hospice, the head nurse could only recommend nine patients who would make good interviewees for my research.

felt “religion would support their *kokoro* when facing death.” But in an earlier 2008 version of the survey that asked *who* would support their *kokoro* the most when facing death, most of the respondents indicated their spouse and/or children (77% and 71%), friends (30%), or even their doctor (28%), while only 5% percent felt a religious professional would help support their *kokoro*.²³ In other words, it is not so much that Japanese patients have a poor image of religion so much as a poor image of religious professionals.

This suspicion toward religious professionals was particularly exacerbated after the new religious group Aum Shinrikyō オウム真理教 carried out the sarin gas attack in the Tokyo subway system in 1995.²⁴ In the aftermath of this attack, new legal restrictions were placed on religious groups and public trust in religious organizations reached an all time low, at about 13%.²⁵ In a climate where the media regularly portrayed religious groups as dangerous entities, religious workers in medical settings were forced to temper their approach. For example, one Catholic hospice chaplain explained that prior to 1995, she would often introduce herself to patients as a “religious provider” (*shūkyō teikyōsha* 宗教提供者) and patients would respond positively. After the Aum incident, she began describing her work as simply “*kokoro* care” to avoid a negative reaction.

The cumulative effect of these cultural and practical concerns is that spiritual care in the Japanese hospice only occasionally requires chaplains to draw on their religious expertise in dealing directly with patients. Instead, their explicitly religious roles are mostly confined to leading morning assembly or other religious services where they may lead a sutra recitation, sing

²³ Japan Hospice Palliative Care Website, “Hosupisu kanwa kea ni kansuru ishiki chōsa (2006-2012),” <http://www.hospat.org/research-top.html> (accessed March 31, 2017).

²⁴ Baffelli and Reader, “Impact and Ramifications,” 1-28.

²⁵ Kisala, “Asian Values Survey,” 65.

hymns, pray, or give an uplifting sermon. Instead, chaplains and other hospice workers define spiritual care as having very little to do with religion and more about approaching patients with a heart that shows empathy, respect, and concern in order to help them feel valued.

What does Spiritual Care Look Like?

This section will draw on my ethnographic fieldwork and interviews with hospice workers to consider some specific *ways* spiritual care is practiced. These include what I have termed vocal care, resonating care, and supportive care. These somewhat artificial labels help to outline the range of ways in which spiritual care is practiced. Primarily, they help focus attention on the *way* spiritual care is practiced rather than on the *content* of the care, which, as already noted, could include almost anything. In short, these categories examine what spiritual care looks, sounds, and feels like. Approaching spiritual care from a phenomenological perspective also helps us better understand the embodied nature of spiritual care in the Japanese hospice.

One of the first ways spiritual care is practiced is vocally. Vocal care refers to when spiritual caregivers converse and listen to patients. During such exchanges, words of encouragement are given, personal stories are shared, and deep questions are pondered. This type of care is invariably presented as one of the pillars of spiritual care in professional literature. For example, medical scholar Tanida Noritoshi argues that in contrast to the traditional approach of evidence-based medicine (EBM), narrative based medicine (NBM) forms the basis for spiritual care. Spiritual care is essentially about letting patients voice their narrative, and as the listener provides an affirming ear, the patients create meaning for themselves and find healing.²⁶ Vocal care may on occasion also include religious care. Chaplains may read, recite, or sing scripture

²⁶ Tanida, “Supirichuaru kea: Komyunikeshon kara no tenkai,” 9.

with the patient or answer questions about guilt, forgiveness, anger, or the afterlife from their own religious perspective. For example, one Vihāra priest describes a patient who confessed to him that she had not conducted memorial services for a fetus she had aborted when she was young. Since she strongly felt that her current illness was due to this lapse, the priest hastily arranged for a memorial service that gave her great relief.²⁷

Another type of spiritual care is resonating care. Resonating care places an emphasis on simply *being* with the patient. In addition to affirming the patient's daily life through activities or providing a listening ear to concerns, resonating care sees the presence of the spiritual caregiver as itself a form of spiritual care. By *being* with the patient, the caregiver embodies empathy and allows the patient's suffering to resonate in the caregiver's being. Resonating care also claims no overt forms of care techniques other than spending quality time with the patient. As one nurse explained, "I think the most important thing is to continually be with the patient. The fact is that there are questions that have no answers. I'm sure that the patients aren't necessarily seeking answers—and we don't know the answer anyway. So in such cases, I try to stay with the patient without running away."²⁸ Another nurse echoed a similar understanding when explaining how she responded to patients who asked difficult questions about spiritual issues:

Patients will sometimes worry that they might be burdening their listener, and so they will occasionally apologize [for sharing their worries]. But I try to encourage them to share their thoughts and help them tell their story. Or in cases where there are no answers no matter how much you think about an issue, I say, "It sure is a difficult topic" and if they don't give any further response, I say, "Well, let's think through this together." Then, if it seems like I should leave, I end the visit, but if it seems like it is okay for me to stay, I often remain with the patient for an hour, or depending on the patient, even two hours without any conversation.²⁹

²⁷ Hanaoka Naoki, "Sei to shi no imi o sasaeru: Shūkyōteki ni kakawatta 3 jirei," *Kanwa kea* 22, no. 3 (2012): 229-232.

²⁸ Personal interview, June 11, 2015.

²⁹ Personal interview May 21, 2015.

Prayer might also be included as a form of resonating care. Although prayers are sometimes said aloud for the benefit of the patient (vocal care), they are also silently uttered by chaplains at the bedside of unconscious patients, in chapel services, and at the privacy of their desk throughout the day.

Finally, supportive spiritual care refers to creating a hospice environment that helps the patient affirm their value in the midst of the dying process. At the most basic level, supportive care includes designing hospice facilities and care plans in a way that patients feel at home. Spiritual caregivers also pay attention to and support the patient's favorite activities, arrange for social events, and engage in small talk to help stave off feelings of isolation. It is a form of spiritual care through small touches that in their aggregate helps patients feel valued, appreciated, and supported as they face the end of life.

However, as suggested earlier, since spiritual care often has less to do with *what* the caregiver is doing and more to do with *how* it is being offered, it is not always clear where these different types of spiritual care end and other kinds of care begin. In fact, they can rarely be separated. As one doctor explained to me, the most important thing in spiritual care is simply to “turn one's eyes to the patient's suffering and to listen to them.”³⁰ Or as another doctor put it, “let the patient know that their existence is an indispensable necessity to you” (*hitsuyō fukaketsu na sonzai* 必要不可欠な存在). In other words, the practice of spiritual care essentially means communicating how much the patient means to the caregiver. This communication is sometimes practiced directly, but more often indirectly, as hospice staff go about their daily duties.

In a sense, the Japanese case allows us to consider the important *affective* role of spiritual care. Although some patients do openly bring up *cognitive* questions about “the search for

³⁰ Personal interview, January 21, 2015.

meaning,” the practice of spiritual is also centered on making the patient *feel* valued and needed. The cognitive and affective dimensions of spiritual care are also nicely illustrated in the Japanese word *kokoro* 心, a difficult word to translate, which is often translated as “heart and mind.”³¹ According to Thomas Kasulis, the character for *kokoro*, read *xin* in Chinese, refers to the faculty for thinking or feeling. The affective dimension of the *kokoro* can be traced to premodern Japan when the character *i* 意 (Chn. *yi*), meaning “intention,” was also commonly used for *kokoro*. The fact that both of these characters were used to write *kokoro* attest to the meaning of this word as a “cognitive form of affective sensitivity.”³² With this in mind, when hospice workers stress the importance of caring for the *kokoro* of patients, one might say that this care has an important *affective* function that makes patients *feel* valued. While helping patients work through existential questions about the meaning of their life, or offering religious truths that might provide solace to in the face of death may give patients some peace of mind, care for the *kokoro* also includes a range of activities and interactions between hospice workers and patients that help the patient constantly *feel* their worth.

A “Day” in the Hospice

To better understand how hospice staff members work as a team to help the patient feel valued, this section will examine some of the rhythms of a day in the hospice, such as patient examinations, medical conferences, and patient rounds. While spiritual care is seen as primarily

³¹ For example, the title of Natsume Sōseki’s famous novel, *Kokoro*, is left un-translated in English.

³² As Kasulis further notes, translating the Japanese *kokoro* as “heart and mind” is problematic, since it reinforces the dualism between the affective and the cognitive that are blurred in the word *kokoro*. Even Western terms like “psyche,” “soul,” “anima,” and “spirit,” fall short in that they suggest substantial entities rather than a “mode of relating” or “being in touch with something or being touched by it.” Thomas P. Kasulis, “Cultivating the Mindful Heart: What We May Learn from the Japanese Philosophy of *Kokoro*,” in *Brain Science and Kokoro*, ed. Paul L. Swanson (Nagoya: Nanzan Institute for Religion and Culture, 2011), 3-7, accessed April 1, 2016, <http://nirc.nanzan-u.ac.jp/nfile/3712>.

the work of the chaplain, doctors and nurses are also active in doing what they can to lessen any underlying anxieties the patient might be feeling by making them feel valued. Since the closest corollary to spiritual care is caring for the patient's *kokoro*, spiritual care is by no means limited to religious workers. By examining some of the rhythms of daily life in the hospice, we can also see how spiritual care involves emotional labor—a form of labor in which caregivers must manage their own *kokoro* in order to make the patient feel appreciated and valued.

Initial Examination

Since most hospices in Japan have a long waiting list, a new hospice patient is received almost immediately after a bed opens, usually by the next day. After the new patient has settled in, the attending doctor and nurse visit the patient's room for an initial examination. The physical examination is fairly simple. The doctor will listen to the patient's heart, lungs, look at the patient's eyes and mouth, and check the feet for swelling and to measure blood circulation. Next, if the patient is still alert, the doctor will ask a number of questions such as: "What hurts the most?"; "On a scale of one to ten, how much does it hurt?"; or "Does anything else hurt?" If the patient cannot respond or is suffering from dementia, the attending family members will answer for the patient to the best of their ability. After ascertaining the extent of the person's pain and discussing possible treatments, the doctor then confirms the patient's awareness of his or her own condition. "Do you know the name of your illness?" "How much were you told by your previous doctor?" Finally, the doctor will ask the patient how much he or she wants to know about their prognosis, a delicate procedure known as informed consent.³³

³³ For an in-depth study of the ethical dimensions of informed consent in Japan, see Laura Specker Sullivan, "Justifying Ethical Claims Across Cultures: A Global Bioethics and Informed Consent in the U.S. and Japan" (PhD Diss., University of Hawaii, 2015).

One technique of broaching the subject of informed consent with patients in Japan involves the use of hypothetical patient types. Instead of directly asking the patient, “How much would you like to know?” the doctor provides the patient with a set of choices: “So in regard to being informed about your illness, some patients would like to know everything down to the last detail, while others are content to leave most of it to the doctor (*omakase suru* お任せする). Which kind of patient are you?” Answering this question is not always easy. Kaneda-san was a forty-nine-year-old patient who mulled over the question for a while before replying: “I used to be the type who wanted to know everything. However, as things got worse and my previous doctor told me the end...[she started to choke up] is near, I don’t care as much now.” As Kaneda-san’s family members also began to get teary, the doctor gently reassured them that he would take great care to make sure that she felt as little pain as possible throughout her stay.

After meeting with a new patient, hospice staff excuse themselves from the room and meet with family members separately. During this meeting the doctor attempts to gather additional information from the family’s perspective. For example, in the case of Kaneda-san, the family shared how she never complained about her pain for fear of being bothersome (*meiwaku* 迷惑) to her caregivers.³⁴ She did not even mention the pain from her bedsores until her sister discovered them. The family also explained that Kaneda-san was feeling guilty about dying while her father was still alive, since this meant that the responsibility of care for her aging father would rest entirely on her sister’s shoulders. As family members spoke through their tears, it was obvious that they were very pained by how Kaneda-san was still putting her family’s needs ahead of her own. In fact, Kaneda-san had previously told her family that she was giving

³⁴ The fear of becoming a burden on others is one of the most common sources of anxiety for patients that will be explored further in Chapter Four.

up eating so that she could die sooner and become less of a burden. To her family's relief, once she found out that she would be able to enter the hospice, she began to eat again. The doctor finished the meeting with Kaneda-san's family by gently but plainly explaining that the patient's condition was very *kibishii*. But as the patient's father and sister continued to snifle, he tried to end the interview on a positive note by explaining how the staff would be doing their utmost to make sure she didn't experience any physical pain during her stay. In light of the many unknowns about how the remainder of Kaneda-san's life would unfold, medical control of her physical pain was one of the few promises the doctor could make.

Controlling the patient's physical pain is always the first priority of hospice staff. As Cicely Saunders explained to Kashiwagi Tetsuo when he sought to introduce hospice care to Japan, when a patient is faced with pain, "the first thing I would want is not for an experienced psychiatrist to listen to my irritated feelings or a chaplain to pray that my pain will go away quickly."³⁵ Rather, when a new patient is brought in, the first goal is to make sure that physical pain and discomfort is palliated as soon as possible. Without caring for the physical pain, spiritual care cannot even be considered.

However, physical pain can also become the cause of what chaplains term "spiritual pain." For example, one doctor shared a story about a patient who was extremely difficult to deal with. He constantly lashed out at his family and the hospice staff and declared every day that "he wanted to hurry up and die"—a statement that, for many religious professionals involved in hospice care, would amount to a paradigmatic expression of spiritual pain. But during the course of his stay, the medical staff made several medical adjustments including a decision to use a nasogastric tube to help relieve some of his symptoms. When this helped relieve his discomfort,

³⁵ Kashiwagi, *Teihon hosupisu*, 38-39

the patient was a changed man. He became a model of gratefulness and began to frequently express how much his family and other caregivers meant to him. As this patient's doctor reflected on this episode, she noted that what looks like spiritual pain could sometimes simply be a side-effect of physical pain.

Staff Meetings

The shift report (*mōshiokuri* 申し送り) typically takes place immediately after morning assembly, usually around 9:00 a.m. The doctors, nurses, pharmacist, social worker, and chaplain gather in a room adjoining the nurse station while the night shift shares a rapid fire report on the patients' conditions and whether anything notable occurred during the night.

Suzuki-san (ovarian) arrived yesterday. Can't eat.
 Genmoto-san (breast) is taking Betanis. Needs help with the toilet. Requires at least two nurses. Has strong delirium. Her delirium has gotten progressively worse since the recent death of her husband. She is a little senile, and has probably a month left.
 Arima-san (lung)—we did a rescue [dose] during the night. Switched to IV, and is dozing. Some nausea. Her husband wants to feed her but we are stopping her food.
 Wakayama-san (ovarian) is taking Dormicum, wants to sleep more.
 Matsui-san (colon) has maybe a week left. No food. No pain. Some communication. Mostly sleeping.
 Soga-san (stomach) is as usual.
 Uchida-san (colon) is doing better. Eating a third of her food.
 Natsume-san (esophagus) is delirious and showing apnea. Lasting out the week is difficult (*kibishii*). Her family is ok with it, saying: 'It can't be helped.' Natsume-san herself is calm.
 Kuribayashi-san (breast) is getting worse. She is still sitting up and using the internet though.
 Akita-san (lung) is doing well.
 Hirai-san (breast) vomits her food. No big change.

Although the core of the report is an overview of patients' medical symptoms, occasionally, there is an extended discussion of other issues. For example, staff also consider the patient's family and financial situation or reference the daily activities of patients. "A-san was pretty tired

from visiting with family yesterday.” “B-san couldn’t sleep and went to the chapel early this morning.” “C-san’s wife’s birthday is in October— he probably won’t last that long but can we help him make a birthday card?” In general, however, nonmedical updates are reserved for discussion during the workday or in private interchanges.³⁶

The next time the hospice team gathers is during the afternoon conference; this may be held daily or as seldom as once a week depending on the hospice. Its purpose is to exchange information and to formulate care plans for patients at a depth not possible during the morning shift report. Sample topics include discussions about the appropriate titration of drugs, whether to allow a patient to go home for the weekend, what to do with a patient who won’t stop pushing the nurse call button, and how to explain a care plan to family members who felt medication was actually making the patient weaker.

Staff also take time to reflect on and evaluate their care for past patients. During an afternoon conference at a Protestant hospice in Kyūshū, the hospice team discussed Fukuda-san, a woman in her mid-seventies, who had recently passed away. During her final days, Fukuda-san repeatedly asked the staff to raise her sedation levels and to “let me sleep.” The nurse consulted the chaplain who initially expressed hesitation since there seemed to be no obvious medical reason to raise her level of sedation. He worried that she might be relying on the sedatives to overcome a kind of “spiritual pain” she felt in the face of death. But when they consulted Fukuda-san’s daughter, she asked the staff to respect her mother’s wishes. The daughter informed the staff that her mother was the type of person who liked to be in control and the adjustment of her medication was one of the last ways she could exert control over the end of her

³⁶ For example, as nurses returned to the staff station after the report, there was often an outpouring of conversation as they informally exchanged information about patients or pulled a doctor aside to discuss a specific issue.

life. Even though the daughter valued being able to communicate with her mother, she explained how even more painful it was for the family to see her mother waste away in a manner that seemed so unlike her. Ultimately, the doctor agreed to slowly raise her sedation level and she passed away shortly after that.

As the staff now discussed whether raising her sedation levels had been the right decision, the chaplain noted that in light of Fukuda-san's wishes, he agreed with the doctor's decision. As he noted, this was not really a case of trying to stifle the patient's "spiritual pain" through over-sedation—an action he would oppose. Rather, it represented a case where a patient simply wanted to *be herself* by retaining control over her treatment, even during her final days. In this case, the chaplain argued, it made sense to respect her wishes and switch her to a deeper sedation even if her physical pain levels did not warrant it and it meant fewer opportunities for communicating with her. Another doctor reaffirmed how Fukuda-san was an exception to the principle of not sedating patients without medical reason, saying that he too thought that just because it is difficult to look at patients' suffering, in the majority of cases, this was no reason to put them into deep sedation. In his view this was what spiritual care was for and what made the hospice distinct from regular medical care. He observed that their job as hospice professionals was not to shrink from suffering or to sedate patients for the staff's convenience. Ultimately, in his view, this case helped remind them of the challenge in finding a balance.

This case also illustrates the ways in which spiritual care can potentially be at odds with other types of care. For example, if this patient was simply tired of wasting away in bed and wanted a higher level of sedation as a way to forget her daily misery, it would have been questionable if staff had felt comfortable acquiescing with her request. If it was simply an issue over physical discomfort or pain, it may have been reasonable to help her "sleep." But from the

perspective of hospice workers who are also committed to giving spiritual care, however, sedating her without medical reason might have failed to address a potential “spiritual pain” that was the real cause of her misery. However, after learning more about the patient and realizing that it was her inability to control her sedation levels itself that prevented her from “being herself,” this tension was resolved to everyone’s satisfaction.

Patient Rounds

One morning, I followed Dr. Kuroda as she did her rounds. The first patient we visited was Arima-san whose hands and feet, which, as we had just learned during the morning shift report, were getting colder. When we entered the room we could immediately see that she was breathing very hard. She had lung cancer and one lung had completely collapsed, causing her chin to jerk up with each shallow breath. An oxygen mask covered her mouth and helped her breathe. Her husband was sitting by her side and occasionally reached under his glasses to dab his eyes with the corners of his handkerchief. Dr. Kuroda gently took Arima-san’s hand, stroked it and softly greeted her. She then explained to the husband that even though the jerking of her chin looked painful it was involuntary at this stage and did not necessarily mean she was in pain. “Please let us know if you see her furrowing her brow or anything else that might indicate pain and we can give her some more sedatives by IV.” She gently uncovered the patient’s feet and felt them in her hands. “Still warm.” She then addressed the patient with some encouraging words: “Your son will arrive in a little bit.” As the doctor prepared to leave, Arima-san’s husband asked her, “Is it possible that her condition will take a sudden turn?” “I’ll explain later” Dr. Kuroda replied.

After we left the room I asked Dr. Kuroda what she normally says to patients and their families at this stage. “There isn’t much I can say to the patient. I just make sure they aren’t in pain and try to comfort the families by letting them know that despite appearances, the patient is not necessarily in pain. I also tell them that their presence beside the patient is the best medicine we can give.” After we walked back to the nurse station, she conferred with the attending nurse. “Arima-san probably has only a few hours left. Let’s call her son and see if he can hurry.”

I inquired about the medicines she was giving Arima-san: “Mostly morphine.” She was also taking medication to help with her nausea and had been taking steroids (although she was off them now), as well as sedatives like Dormicum and Seconal to help her sleep. Dr. Kuroda explained that in her experience cancer patients typically died in one of two ways. One is when they stop breathing (for example, in the case of lung cancer), and the heart stops shortly afterwards. The other way is a slow weakening when they can no longer eat.³⁷ Arima-san was likely to follow the former pattern.

Dr. Kuroda went back to the room, motioned to the husband to join her in the hallway and asked when his son would arrive. “He is on his way.” She then answered the question he had posed earlier about his wife’s condition. She explained that at this stage, a change for the worse could happen anytime and recommended that he gather the family right away. “I think they can come this afternoon,” the husband suggested. The attending nurse interjected softly but urgently,

³⁷ In some cases, if a patient has ascites (abdominal swelling), dying may take longer due to the fluids trapped in the body, which contain nutrients. According to Dr. Kuroda, one patient in their hospice lasted for a month living off the fluids produced by his body. Most doctors also prefer to stop giving food and liquids to patients at the end since it causes them unnecessary pain. Almost all the nutrients from food go straight to the cancer and drinking liquids also increases the amount of phlegm in the throat, which is difficult for weakening patients to cough up. However, these medical realities must also be balanced with the wishes of family members who can’t help but feel that their loved one is only getting weaker without food or water.

“It is a matter of hours and so this afternoon might be...” The husband was taken aback. His face showed that he was just beginning to register that the end had finally come. “Okay, I will call them right now.”

Leaving Arima-san’s husband behind, next we went across the hall to visit Kuribayashi-san, a female patient in her mid-sixties who had breast cancer. Before we entered the room, Dr. Kuroda mused out loud, “Breast cancer really takes a long time.” When we entered her room she was reclining on the bed with an oxygen tube under her nose. Unlike Arima-san, she was alert. I marveled as Dr. Kuroda quickly changed from the thoughtful and somber demeanor she had maintained with the previous patient to a joking manner. We both laughed as Kuribayashi-san referred to her scheduled bath as a visit to the “hot springs.” She was very sharp and witty. I learned that she liked to go online and order various things. She sometimes ordered meals to be delivered to the hospice, including from Mos Burger, a Japanese hamburger chain.³⁸ On another occasion she purchased some large hot pots online and then invited the hospice staff to join her for a hot pot party in her room. A photo of the party was pinned to the bulletin board by her bed next to several photos taken during a Christmas party event. As we spoke, Dr. Kuroda joked that since Kuribayashi-san was always cheering her up she was not sure, between the two of them, who was the real doctor.

Next, we visited Soga-san, a female patient in her mid-eighties, who was suffering from stomach cancer. She looked a little surprised when she saw my foreign face behind the doctor but relaxed once she heard that I spoke Japanese. She began chatting about how she first met Americans after the Second World War. She was a teenager when the War ended. She recollected how at the time, pretty girls were told to smear charcoal on their faces so that

³⁸ This caused a great laugh amongst staff, since nobody on the hospice staff had any idea that this particular restaurant chain provided deliveries.

American soldiers wouldn't approach them. "I didn't need to since I was homely anyway," she said modestly. Dr. Kuroda and I hastily disagreed. She had also learned a few English phrases during the American occupation, including the phrase: "I can't speak English." I complimented her on her pronunciation. She noted that without a language barrier, foreigners felt closer. As a matter of fact, I was the first foreigner she had ever spoken to. Inside, I knew I was also going to be the last. I told her it was an honor to meet her. As we left the room, she made an effort to sit up in bed and thanked us for coming. "Please come again."

The next patient we visited was Matsui-san, in her late sixties, whose colon cancer was pressing in on her spinal cord and affecting her nervous system. She constantly felt a burning or tingling sensation in her leg. Since morphine is less effective for nerve pain, Dr. Kuroda was treating her with analgesics and a few other drugs that were used to alleviate spasms. When we entered the room, she was lying back on her bed with her brother and sister by her side while the TV played at a low volume in the background. She had received some aromatherapy treatment in the morning and her nails had been painted a nice pretty pink. Her bright pink nails stood in contrast with her gaunt frame and drawn skin. Her mouth was cracked open showing her teeth in a perpetual smile. She could not voice words anymore but she was still alert and could clearly follow everything the doctor said to her.

After a short visit with Matsui-san, we went and peeked in on Arima-san again. By now more family members had arrived. Her breathing was slowing and with every breath and she made involuntary noises in her throat. Her family was becoming quite teary. We left the room, and with that, the morning had come to an end. Dr. Kuroda went to her desk to eat lunch, and I went to eat in the cafeteria. As I admired the lunch of the day, a bowl of steaming rice with some tasty tempura on top of it, I wondered how hospice staff were able to compartmentalize their

work. How could I enjoy the lunch set before me when Arima-san was gasping for breath upstairs? How do hospice staff balance their emotions while going so quickly from one room to another?

One way to understand how hospice staff members manage their emotions is through the idea of emotional labor. As Arlie Russell Hochschild explains, emotional labor requires workers to “induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others.”³⁹ In her study of how flight attendants attend to the stress of dealing with rude or exacting passengers, Hochschild notes that airline workers are trained to manage their feelings carefully, smiling always, even when they are seething inside. As my experience on the patient rounds illustrates, doctors, nurses, and chaplains also engage in this type of intensive emotional labor. Dr. Kuroda’s ability to shift from projecting a somber, sympathetic conversation with the family of Arima-san who was on the verge of dying to a light-hearted, carefree conversation with Kuribayashi-san was no easy task. Since spiritual care is about *how* one engages with patients, emotional labor is indispensable to its practice.

Saying Goodbye

No sooner had I finished reflecting on the morning than one of the doctors peeked in the cafeteria, motioned to me and said, “It’s time for final care” (*ima, mitori* 今、看取り). I quickly returned to the ward and found Dr. Kuroda at the nurse station. She was just about to look for me. Arima-san had passed away. The nurse explained that as Arima-san approached the end, it sounded to those in the room that she had mouthed the word “water,” and so family members

³⁹ *The Managed Heart: Commercialization of Human Feeling* (Berkeley: University of California Press, 1983), 7.

took turns swabbing her mouth.⁴⁰ About twenty minutes later Arima-san stopped breathing. I went with Dr. Kuroda and the nurse into her room. It was packed with her husband, children, and their spouses. Everyone was crying very hard. Arima-san's husband sat on one side of her bed and kept calling out her given name. "Michiko, Michiko!" Dr. Kuroda went to the other side of the bed, took Arima-san's hand, and addressed her: "Please allow me to conduct your final examination." She checked her chest for a heartbeat and confirmed that she had died. "We have confirmed her death at twelve o'clock, forty-two minutes, and thirty seconds." Both she and the nurse then deeply bowed to the patient for about ten seconds. After bowing, Dr. Kuroda addressed the patient one final time. "You did a great job. Thank you for your hard work." The nurse encouraged the family to surround the patient and say their goodbyes. As we left the room and walked back to the Nurse Station, Dr. Kuroda was silent. I didn't want to break the silence either. Finally, as she sat down on a stool and opened the patient's chart to make the final entries, she commented: "Since the family was crying that much, they must have really loved her."

When a patient passes away, the last entry on their medical chart notes that they have been "discharged" (*taiin* 退院) from the hospice. Ultimately, for most patients, death remains the only way to kill their cancer permanently. After the doctor confirms the patient's death, family members are given some time to say their goodbyes in the patient's room. In the meantime, the funeral home is called and nurses discreetly help the family tidy up the patient's personal possessions. Before the patient is discharged, the hospice may also conduct a small "goodbye ceremony" (*owakare-kai* お別れ会). This ceremony is optional but many families

⁴⁰ This is also a ritual of parting between the family and the dying person going back to the medieval period. It is now often conducted during the funeral, but the rite may have arisen from the custom of moistening the mouth to facilitate the continuous chanting of the *nenbutsu* at the time of death. Jacqueline I. Stone, "With the Help of Good Friends: Deathbed Ritual Practices in Early Medieval Japan," in *Death and the Afterlife in Japanese Buddhism*, Jacqueline I. Stone and Mariko Namba Walter eds. (Honolulu: University of Hawai'i Press, 2008), 76.

welcome it. The ceremony is usually held in the patient's room or in the hospital mortuary (*reianshitsu* 霊安室). If the patient was a Christian, it may also take place in the hospice chapel. At Buddhist hospices, the ceremony is held in the Vihāra hall.⁴¹ During this ceremony the patient's bed is placed in front of the Buddhist altar, on which a favorite item of the deceased, such as a family photo, is placed on the altar. On one occasion the Vihāra priest placed a can of coffee on the altar in memory of a patient who had liked to frequent the hospice vending machine in pursuit of some afternoon caffeine. At Christian hospices, the goodbye ceremony invariably opens with the hymn, "What a Friend We Have in Jesus" (*Itsukushimi fukaki* 慈しみ深き), while at Buddhist hospices, priests chant one of the sutra recitations used during *omairi*.⁴²

During the goodbye ceremony, the patient's attending doctor, nurse, the chaplain, and other staff take turns sharing their memories of the patient. This is also a chance for the family to thank the doctor and nurses for their care. When the funeral workers arrive, they carefully transfer the patient to their own stretcher. Although the deceased's face is normally covered with a white sheet, some hospices make a point of leaving the patient's face uncovered. This is to emphasize that death is not something to be hidden. Some hospices also purposefully take the patient out the front door of the building instead of the traditional back door.

As these vignettes demonstrate, hospice doctors and nurses spend much of their day focused on helping to remove physical pain, ensuring that patients are in as much comfort as possible, and communicating with family members. However, this is not to say that they do not

⁴¹ Of the seventy eight patients who died between April 2010 and August 2011 at Asoka Vihāra Hospital, forty-eight (63%) of families requested a goodbye ceremony. But this also depended on the time of day when they died. For example, 89% of patients who died during the day received a goodbye ceremony while only 46% of patients who died during the night received a goodbye ceremony. Baba, Hanaoka, and Tsukie, "Shūmatsu iryō no naka ni okeru jōchū sōryo."

⁴² *Amazing Grace* or *Till We Meet Again* is also sung on occasion at Christian hospices.

see themselves as also providing spiritual care. For example, adjusting or changing a patient's morphine or fentanyl titration to relieve pain, or allowing the patient to exercise control over their level of sedation are seen as important ways to let the patient "be themselves." This in turn communicates to the patient that they are highly "valued" and their lives have meaning. Doctors and nurses also try to use small talk and compliments during their rounds to foster intimacy with patients, letting patient concerns "resonate" in their hearts, or just sitting for a time next to semi-conscious patients and stroking their hand as they struggle to breathe. As one nurse who had worked in hospice care off and on for nine years explained, "Even now, when I get questions from patients [on the value of living] I still don't think there is a right answer for what to say or how to interact with them, and I still worry about this; I just try not to run away. I just try to listen carefully to them, and to interact in a way that shows that I'm trying my best to understand their feeling of suffering."

The Role of Religious Professionals

While doctors and nurses may view their care for the patient's physical and other needs as an indirect form of spiritual care, chaplains in the hospice are free to interact with patients in ways that more directly communicate how much they value patients. For instance, vocal care and resonating care remains an integral part of the chaplain's rounds. During their visits with patients, chaplains offer encouragement, lend a sympathetic ear, and sometimes just sit with them. However, chaplains also do a lot of things. This includes leading social events and seasonal activities, and even gardening. This section will focus more closely on the work that the chaplain does in the hospice. It will also examine the claim by chaplains that regardless of appearances,

their religious beliefs and practices remains integral to their work since it gives them a “stability” that patients are attracted to.

Visiting with Patients

When I first met Sister Yamada, who served as a chaplain at a Catholic hospice in Kyūshū, I was impressed by her practical approach to patient visitation. She explained that there were basically two kinds of patients: those who are forward looking (*maemuki* 前向き) and those who are backward looking (*ushiromuki* 後ろ向き). She explained, “As for those who are counting the days until they die, they are impossible to help. If they are backward looking, you can’t really help them until they realize they are looking the wrong way.” Her job, she felt, was to help patients realize how precious their lives were.

As I shadowed Sister Yamada on her rounds, several of the patients we visited were sleeping or only slightly responsive. Then she introduced me to Uejima-san, who during our first meeting introduced herself by saying, “I am cancer. Cancer is my friend. We are doing well together.”⁴³ When I explained that I was interested in how hospices provided care for the *kokoro* of patients she responded, “The *kokoro* is weak.” Sister Yamada chimed in, “If you can say that you are friends with cancer, your *kokoro* is not weak! Not only that, when you say that you are happy in the hospice, this is like medicine for the *kokoro*.” The second time we visited her, Sister Yamada asked her again how she was doing.

U: “Good.”

Y: “You look well today, too.”

U: “Really?”

Y: “It sure would be nice if things stayed this way.”

⁴³ It is not uncommon for patients to say, “I am cancer” (*watashi wa gan desu* 私は癌です), meaning they “have” cancer.

U: “But you never know when things will change.”

Sister Yamada then paused, sensing that her last remark might have been insensitive to someone to whom death was imminent. Instead of trying to cover it up or change the topic, she addressed it directly. Sister: “It’s not good to say something like that to someone who can’t stay the same way, is it?” Uejima: “No, I suppose not.”

During Sister Yamada’s daily rounds, she would often ask patients how they were doing, what they had been up to, and who had visited them. As patients responded, she would praise and compliment them. For example, when family members were present she would often comment: “How lucky you are to have such a caring family member who spends all this time with you!” Her cheerful approach was also evident during a review session with an intern who was studying spiritual care. The intern shared how she sensed something positive behind one patient’s outwardly pessimistic demeanor. Sister Yamada advised her to try and pick up these positive glimmers and to mine them further when conversing with the patient.⁴⁴

However, visitation with patients did not always involve conversation since many patients were unable to communicate. For example, one patient was rarely conscious. When we visited his room one day, I was caught off guard when, after saying a few words of greeting, Sister Yamada suddenly began singing a hymn to him. After she finished, she leaned in close to his ear to tell him, “Jesus will protect you and be with you.” When I later asked her about this patient, she explained that he had led a very rough life and in his own words, “had done everything but murder and drugs.” He was divorced and had no family to visit him. But in his

⁴⁴ This is not to say that she was always trying to cheer up patients. As a former hospice nurse, Sister Yamada was well acquainted with the importance of allowing patients to express themselves honestly. But she also emphasized the need to help patients find things to be thankful for no matter how depressed they might feel.

youth, he had attended a Lutheran school for six years and told her that he enjoyed hearing hymns—hence, her spontaneous burst into song.

Another patient had also lost her ability to talk. When we visited, she tried communicating to us but kept waving her hands in frustration since she could not form her words very well. After a while, Sister Yamada picked up a very fancy photo portrait of the patient's grandson from the table beside her bed. She asked, "Is this photo from his coming of age ceremony?" The patient gestured to say no. "Then, perhaps for a marriage interview?" She gestured no again, and her face showed her frustration and disappointment. I sensed she was about to give up. Sister Yamada persisted, "Then, maybe your grandson just sent this to you to say, 'Look, Grandma, I'm all grown up now?'" As soon as the words left the Sister's mouth, the patient's hand shot up to her eyes and she burst into tears. We stood quietly while she dabbed her eyes with tissues and looked fondly at the photo. She then mouthed the words, "Thank you."

At other times, it could be difficult to encourage or empathize with patients even if they could talk. For example, Takagi-san was in her late seventies and came from Nagoya. When we entered her room, she sat up immediately and continued to sit with ramrod posture on her bed despite Sister Yamada's best efforts to have her shift to a more comfortable position. Sister Yamada visited her several times, but she never seemed totally relaxed in the chaplain's presence. She was cordial each time, but remained guarded and kept a polite distance every time the chaplain inquired how she was doing.

Shitakubo-san was another reserved patient in his early seventies with lung cancer whom I met in a Buddhist hospice. Many patients wandered through the ward in their pajamas, but he always changed into a dress shirt before visiting the common areas where he spent many afternoons working diligently on his laptop. He explained that he was the coordinator for his

annual middle school reunion, which was going to be held at the end of that month. It was doubtful whether he would make it, but he sought to put all the reunion files in order so he could pass these on to a classmate for subsequent years. He was very punctilious and independent. He also resisted allowing the nurses or even his wife to help him go to the bathroom.

When we visited him in his room one afternoon, he was a little sleepy but alert. The Vihāra priest, Rev. Sasaki, spoke with him about his eldest son who had visited the day before and about his two other children. Shitakubo-san was concerned about who would take care of the family's Buddhist altar. He doubted his eldest son could do it, and it was not clear if his second son would be willing to move home. He had considered the possibility of selling the house and dividing the estate between the children but was worried that once the house was gone the siblings would go their separate ways.

After we left his room, the Rev. Sasaki explained to me how important it was to have these kinds of conversations with patients. Although Shitakubo-san showed little concern for his own condition, he did worry over what would become of his family. Rev. Sasaki saw himself as playing a mediating role by conveying information to family members who found it difficult to discuss these issues with Shitakubo-san directly while he was still alive. We visited Shitakubo-san again after he had spent a night at home. After chatting about how things went, Rev. Sasaki commented: "Shitakubo-san, you aren't really the type to outwardly express anxiety (*fuan* 不安), are you?" He replied: "I might just be thickheaded... I'm an atheist too..."⁴⁵ After we left his room, Rev. Sasaki mentioned to me, "I think that he is feeling spiritual pain somewhere. He calls himself an atheist (*mushinronsha* 無神論者) but he uses the Buddhist

⁴⁵ According to Rev. Sasaki, his remark about being an atheist seemed to be a veiled apology for not being able to converse on spiritual issues with the Vihāra priest.

word for “life and death” (*shoji* 生死) and I saw him reading a book about Shinran 親鸞.⁴⁶

Japanese simply just don’t show their religious views much up front.”

Both chaplains and other hospice staff were well aware that many patients were reticent to share their personal, let alone spiritual, concerns, if they had any. It took time to connect with patients. As one doctor put it, you don’t want to “step into their *kokoro* with your shoes on” (*dosoku de kokoro ni agarikomu* 土足で心に上り込む). This reluctance amongst Japanese patients to talk candidly with caregivers about personal issues is certainly not unique to the hospice setting. For example, Japanese psychiatrists are also known to emphasize non-verbal approaches with clients by using sandbox, clay sculpture, and especially box garden therapy (*hakoniwa* 箱庭) to help Japanese express their feelings.⁴⁷ In the next chapter I will examine this reticence more closely and discuss whether hospice patients might conceal deep personal, or existential concerns from their caregivers. What is important to note here is that due to the general reluctance of Japanese to share personal problems with outsiders, hospice workers cannot rely on expecting patients or family members to vocally hail them or even respond candidly to questions about “spiritual” concerns they might have.⁴⁸ Even silently “being there” for patients and showing empathy for their condition through resonating care requires a level of intimacy that takes time to develop. Accordingly, like other hospice staff, chaplains rely extensively on supportive care, a type of care where they strive to create an environment where

⁴⁶ Shinran (1173-1263) was the founder of the Shin Buddhist sect.

⁴⁷ Thomas H. Hohenshil, Norman E. Amundson, and Spencer G. Niles eds., *Counseling Around the World: An International Handbook* (Alexandria, VA: American Counseling Association, 2013), 102.

⁴⁸ By contrast, when I was interviewing a chaplain in the cafeteria of an American hospital, a woman who walked by our table interrupted our conversation to ask the chaplain, “Are you the chaplain? Could you please visit and pray with my son?” It is hard to imagine this kind of interaction occurring in a Japanese hospice.

the patient can “be themselves” and find meaning in the end of their life through feeling valued and appreciated for who they are.

Supportive Care

While it may seem odd to speak of designing hospice facilities with spiritual care in mind, hospices take great pride in their facilities, which are prominently featured in promotional pamphlets. In addition to spacious rooms, common areas and kitchens, soft lighting, flowers, and lots of artwork, hospices also make a point of removing as many signs of medical care as possible. For instance, oxygen connectors in patient rooms may be disguised, and several hospices I visited featured a rollup shade that can be pulled down over the bathroom mirror so that patients do not have to be reminded of how their physical appearance has deteriorated during their stay. Many hospices also provide patients the option of staying in a *tatami* mat room, since many Japanese wish to “die on top of the *tatami* (畳の上に死にたい), which evokes the image of a natural death.⁴⁹ Even as signs of medical care are removed from view, Christian and Buddhist hospices replace them with religious objects. Rooms and hallways are tastefully decorated with religious artwork and symbols while the chapel, Vihāra hall, or prayer or meditation rooms are made available for patients to use.⁵⁰ At a recently constructed Buddhist hospice in Kyūshū, the entire ward was built with Japanese cypress trimming by *miyadaiku* 宮大工, carpenters who specialize in the traditional art of building beautiful temples and shrines

⁴⁹ Long, *Final Days*, 62-63.

⁵⁰ Even if they are not used, they establish a certain atmosphere. For example Nakahara utilizes James Gibson’s work on “affordances” to discuss how the physical features of the hospice are designed to “afford” patients spiritual care. Thus an empty chair facing the Buddhist altar might invite or afford the patient an opportunity to pray. Nakahara Toyoko, “Gan kanja ga bihāra ni nyūin shi byōtō to iu kyōdōtai no kōseiin ni naru katei” (paper presented at the Bukkyō kango bihara gakkai, Higashi Betsuin Temple, Kanazawa, Japan, August 30, 2015).

without using any metal or nails. When I visited this hospice shortly after it opened, I was greeted by a lovely cypress fragrance that made me think I had literally walked into a temple.

At a Buddhist hospice in rural Kyoto, the back garden emerged as an important site of supportive spiritual care. The Vihāra priests spent many hours working outdoors alongside patients, and sometimes even by themselves. One priest explained to me that even when patients could not join them, it was important for patients to be able to hear the sounds and see rhythms of home life. The priests would also take patients on nature walks and find ways to surprise them with things they liked. Often they ate lunch with patients and their families in the common room. Although the Vihāra priests also spent time visiting individual patients to talk about spiritual issues, the most striking image of the Vihāra priests during my fieldwork was how they were *living with* the patients.

One priest even used the metaphor of riding a bicycle to explain the importance of this type of spiritual care. After asking me how wide a path I thought was necessary to ride a bicycle, he noted that a path really only needs to be as wide as the bicycle tires—perhaps three centimeters. But if you made a path that was only three centimeters wide and asked someone to ride on it, that person would be scared. It is only because you have space on either side that you can ride the bicycle confidently. In the hospice, he explained, medical care corresponds to the part where the tire touches the ground; it is indispensable to running a hospice. But the Vihāra priest's job is to be the rest of that path. Without the support of spiritual care that the Vihāra priest provides, entering the hospice would be a scary ride.⁵¹

⁵¹ A chaplain at a Protestant hospice in Kyūshū also echoes this description of spiritual care. He explains that the design of hospice facilities, small talk with patients, and various events and activities all function as a form of “spiritual support.” Kiyota Naoto, “Hosupisu kanwa kea ni okeru supirichuarukea no teigi” (paper presented at the Nihon supirichuaru kea gakkai gakujutsutaiikai, Kōyasan University, Wakayama, Japan, September 12, 2015).

Much of this support is provided in the form of social activities. One of the distinguishing features of the hospice is the constant flow of events and activities that are organized for the patients. Music therapists come weekly, as do animal therapists, aroma therapists, and even beauticians. Most of these professionals are volunteers or supported by non-profit organizations. Baristas visit weekly to make coffee, or an experienced tea ceremony volunteer makes green tea for patients and family. Musicians come to give small concerts, comedians present a routine, and at one hospice an expert sushi chef even came to prepare and serve fresh sushi to patients. As TV documentaries and publications have helped raise the profile of hospice care in Japan, volunteers are eager to offer their services. In fact, some volunteers are even too eager. For example, some prospective volunteers request to serve in the hospice but withdraw their offer or quit shortly after being asked to serve in a regular ward instead.

In addition to weekly events provided by volunteers, hospice staff also arrange for different seasonal events. At Christian hospices, Christmas is a big event: patients gather together to sing Christmas carols, receive presents, and take pictures with Santa.⁵² In the spring, patients are wheeled outside for cherry blossom viewings, and during the summer, staff might set up a festival (*matsuri* 祭り) for patients. At a Buddhist hospice, I helped patients make *ohagi* お萩 (soft rice cakes covered with sweetened red bean paste) during the autumn equinox.⁵³ Patient birthdays are also enthusiastically celebrated. Afterwards, pictures from these events are given to patients to pin on their wall or to family members as keepsakes.

Chaplains lead many of these activities. In one Christian hospice, a weekly “tea time” takes place where patients and families sing songs, listen to a short Christian message given by

⁵² At one Buddhist hospice, although they did not celebrate Christmas, they held a “fun party” (*otanoshimikai* お楽しみ会) during the Christmas season instead.

⁵³ *Ohagi* are traditionally made for visiting ancestral spirits (and consumed) during the autumn equinox.

the chaplain, and spend time getting to know other patients while eating snacks and drinking tea. At another Catholic hospice, the chaplain leads a weekly gathering called “*kokoro* time” where patients, families and volunteers sing traditional Japanese songs and then share stories on a topic like, “something from this week that made me happy.” Vihāra priests are also proactive in arranging for activities with patients. When the weather was nice, the priests often wheeled patients out for a nature walk through some nearby fields. They were also in charge of the small garden behind the hospice where patients could plant vegetables or flowers. In the fall, harvested onions could even be seen drying on a patient’s veranda.

At times, special events might also be tailored with certain patients in mind. For example, one patient at a Buddhist hospice enjoyed watching films. After learning of this, the Vihāra priests set up a screen and projector in the Vihāra hall and brought in couches. The nutritionist made popcorn, someone else made some movie ticket stubs, and they hastily arranged a film viewing for the afternoon. The room was also rearranged so the Buddha image in the front of the room could enjoy the film—a spaghetti Western. The patient was all smiles as she handed in her ticket and entered the makeshift theater.

One day, Rev. Sasaki showed me a picture of a large (1200cc) motorcycle. It had belonged to a middle aged male patient who was a strong motorcycle aficionado. In fact, he rode the motorcycle to the hospice and parked it on his ground room veranda where he could gaze at it from his bed. His love for the motorcycle was so great that he even used its side mirrors to shave in the morning. Seeing this, several staff members who were also motorcycle enthusiasts arranged to bring their own motorcycles to the hospice and created an impromptu biker rally, much to the patient’s delight. Rev. Sasaski shared this memorable anecdote with me to demonstrate the ways staff tried to make the hospice a place where it was hard for spiritual pain

to arise (*supirichuaru pein ga denikui basho* スピリチュアルペインが出難い場所). Rev.

Sasaki jokingly explained, “You might even say that we are doing preventive spiritual care.”

Supportive care essentially stresses the importance of supporting the patient’s ability to die in a way that reflects who they are (*jibunrashiku shinu* 自分らしく死ぬ). One nurse explained her approach to spiritual care as follows:

If patients can still communicate, we find out what their daily life was like up until this point. Or if it is difficult to communicate with them, we get information from their family and find out what we as a hospital can do to help the patients be themselves. So if eating was something that held meaning for them, even if it is difficult to eat, we let them taste some food. During conferences, we also discuss what the patients need most, and what it is that we can do right now to support them in being who they are.⁵⁴

As these descriptions of supportive care suggest, despite the often repeated mantra in spiritual care literature that it is more important to *be* there for patients than to *do* something for patients, the staff and chaplains in fact *do* a lot of things in the practice of spiritual care.

However, although chaplains openly acknowledge that much of their work is supportive and less about vocally counseling patients or sitting with them in order to let the patient’s existential anxieties resonate in their being, they also gave me hints that they feel a tension in their work. In short, many chaplains felt a tension between the normative images of spiritual care as found in Japanese academic literature on hospices and what they actually do for hospice patients. During my fieldwork, some chaplains were almost apologetic for not being able to provide me with “better” examples of spiritual care. Vihāra priests were careful to explain to me how although it did not “look” like spiritual care, watching a film with a patient, gardening, or chatting about a family member’s recent visit were all indeed part of spiritual care. Likewise, a Christian chaplain in Tokyo explained the lack of “spiritual care” by noting that many patients

⁵⁴ Personal interview, June 8, 2015.

who were experiencing spiritual pain were simply unavailable to him due to the negligence of other hospice staff who had a poor understanding of spiritual care. During an afternoon tea break, a Vihāra priest also reminisced in front of me about a period a few years prior when several patients who were interested in discussing religious topics happened to enter the hospice around the same time and the *omairi* services were always full. He joked to the other priest as he flipped through the pages of his log that this was the “golden age” of their career. Christian chaplains also tended to recount the rare cases where patients found consolation through prayer, faith, or even baptism as the most meaningful instances of spiritual care. Such explanations suggested that chaplains felt the more mundane supportive aspects of their daily work might not look like spiritual care to their American visitor.

Where Religion Fits in After All

Earlier in this chapter I suggested that religion plays only a very minor role in the spiritual care for patients. With the exception of morning services, weekly “tea times,” and other events during religious holidays that are conducted intermittently for the benefit of patients, the explicitly religious role of the chaplain in interacting with hospice patients is typically confined to a handful of patients. However, even though religion is seldom explicit in their dealings with patients, many chaplains stress in no uncertain terms that their religious training and convictions are highly integral to the practice of spiritual care. For example, when speaking with a retired chaplain who had worked for several decades at a Christian hospital in Japan, I once asked if there ever was a discussion in the early years of the hospice movement about the difference between providing spiritual care and religious care to patients. He answered, “No, not at all, we were just doing Christian care.” This comment nicely illustrates how, even though religion

outwardly plays a very small role in spiritual care, spiritual care practitioners can still conceive of their daily work as an extension of their religious commitment toward expressing love and compassion towards others, especially toward those who may be sick or dying. This understanding of spiritual care also dovetails with what scholars have described as “lived religion,” a view that rejects the distinction of religion from the “profane” and instead sees how “religion comes into being in an ongoing, dynamic relationship with the realities of everyday life.”⁵⁵ As Courtney Bender notes in her study of kitchen volunteers, in the right context, counting plastic food containers is “as though I’m praying,” and “cutting carrots is really a lot like meditating.”⁵⁶ In other words, this former chaplain’s comment that he was “just doing Christian care” shows that, just as religious life is interwoven in daily practices and not just lived in religious institutions and communities, spiritual care is often simply a matter of putting one’s own religious beliefs into practice through a range of mundane activities.

Chaplains also suggest that their work is not only an extension of their personal religious life, but that in order to be an effective practitioner of spiritual care, having a robust religious life or set of beliefs and values that serve as an existential anchor is desirable in order to respond to the deep questions that patients might pose in the face of death. As one Christian chaplain explained:

Spiritual care isn’t really about “doing” care. Rather it is about questioning who you are. Meeting with patients challenges you. When people interview and do research on spiritual care, I always emphasize to them there is so much that can’t be academically explained. There are lots of things that are not visible that are important parts of spiritual care...A patient once told me: “I sense something stable (*yuraganai mono* 揺らがないもの) behind you.” This really made sense to me. If am secure in knowing that God loves

⁵⁵ Robert Orsi, “Everyday Miracles: The Study of Lived Religion,” in *Lived Religion in America*, ed. David D. Hall (Princeton: Princeton University Press, 1997), 7.

⁵⁶ *Heaven’s Kitchen*, 62-63.

and accepts me, I just need to be that way before the patient. This is the basis of spiritual care.⁵⁷

From this perspective, spiritual care requires willingness on the part of the spiritual caregiver to be honest, vulnerable, and open to learning with the patient.⁵⁸ But it also suggests that spiritual caregivers must be somewhat secure in their beliefs or values, so they are not at a complete loss when challenged by patients. In other words, it is simply not enough to just value the patient, a type of care that some hospice workers describe as “horizontal.”⁵⁹ Instead, spiritual care can also be “vertical”—a type of care that requires a religious background or existential security that will allow the caregiver to transcend the moment. This is seen to give the spiritual caregiver buoyancy that allows him or her to assist floundering patients.

The role that chaplains’ religious training plays in spiritual care is important since this is also one of the key ways chaplains distinguished their work from that of clinical psychologists.⁶⁰ Although chaplains readily admitted that religious care only constitutes a very small part of their

⁵⁷ Personal interview, June 25, 2015.

⁵⁸ This point is reiterated by Nishino Hiroshi, “Rinshōi no naratibu: Mizukara no supirichuaru pein to mukiatte,” in *Supirichuaru pein ni mukiau: Kokoro no anei o motomete*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku Shuppankai, 2011), 76; Taniyama Yōzō, “Bukkyō ni okeru shi: Bihāra no taiken kara,” in Taniyama Yōzō, Itō Takaaki, and Kubotera Toshiyuki, *Supirichuraru kea o kataru: Hosupisu, bihāra no rinshō kara* (Hyogo: Kwansei Gakuin University Press, 2004): 32; and Konishi, “Chapuren to iu senmonshoku,” 83.

⁵⁹ Kashiwagi, “Yamu hito no tamashii,” 42.

⁶⁰ Other chaplains explain the differences between clinical psychology and spiritual care by pointing out that psychologists are fundamentally concerned with treating the patient using specific counseling therapies that are part of mainstream medicine. In contrast, a chaplain is there to simply listen and empathize, perhaps even to cry with the patient. For instance, a Buddhist chaplain at a hospital in Western Japan was asked by her supervisors to pursue additional certification as a clinical psychologist even as she continued her work of spiritual care. They explained to her that having a clinical psychologist on staff would help the hospital accrue more “points” that were used in hospital rankings, since chaplains do not count. But even after she became certified as a clinical psychologist, she did not observe much change in her work. Though she drew from time to time on her psychological training when she thought a patient might be suffering from depression or mental illness, her approach to work remained the same. This suggests that she did not see her clinical psychological training as adding anything significant to the work of spiritual care; in her mind they represented two different perspectives that informed two different roles. Yet even while she was personally aware of these differences, she also noted that most of the medical staff had difficulty distinguishing between psychological and spiritual care. Personal Interview July 2, 2015.

daily activities, they also pointed out that their work cannot be done by just anyone and that their religious identity remains integral to their work. They saw their role as important precisely because patients enjoy speaking with them, a religious professional, instead of with a clinical psychologist or nurse. Kubotera Toshiyuki, whose theorization of spirituality and spiritual care was examined in the previous chapter, suggests that although spiritual pain is often expressed in terms of psychological stress, beneath the surface exist deeper philosophical doubts, religious questions and a desire for relief (*kyūsai* 救済) that chaplains are better trained to deal with.⁶¹ Moreover, even if chaplains wanted to bracket their religious perspectives when interacting with patients, it is doubtful whether a spiritual caregiver's religious beliefs can ever be fully suspended, even in the clinical context. For instance, one study of Christian chaplains in Japan reported that although chaplains saw pressuring patients to adopt their belief system as antithetical to the nature of their work, many admitted that it was impossible to completely bracket their own religious views when facing patients they felt might be seeking out religious or existential guidance.⁶²

However, even if many chaplains privately view their work as an extension of their religious commitments or their presence as buoys that patients can grab hold of in a sea of uncertainty in the face of death, the allergy many contemporary Japanese profess towards religion requires chaplains to frame their work in the public eye carefully. In order to allow their vocation to become mainstream, they must publicly articulate their roles in psychotherapeutic terms since many Japanese—including their medical colleagues—harbor suspicions that a

⁶¹ Kubotera, “Supirichuaru pein no honshitsu.”

⁶² Fukaya and Shibata, “Supirichuaru kea to enjoshu,” 43-57.

religious professional might have a religious agenda. Consequently, chaplains are careful to present their work as “spiritual” and not “religious” in character.

Conclusion

As this chapter has shown, hospice staff and chaplains go to great lengths to help patients spend their last days in a way that “reflects who they are.” This might involve allowing patients to control their own sedative titration, painting their toenails, buying them watermelon in the middle of the winter, or arranging an impromptu motorcycle show. While these activities look, sound, and feel different from praying with, counseling, or sitting beside patients in their “search for meaning,” they all form the basis of what hospice staff describe as spiritual care.⁶³

Spiritual care in practice also differs in many ways from the Japanese academic and medical models of spiritual care outlined in the previous chapter. Although the spiritual dimension of hospice care is often treated as a distinct from other forms of care in theory, spiritual care in practice often collapses these categories. Hospice staff often conduct spiritual care in the margins of regular care and primarily understand spiritual care as anything that make patients feel valued and allows them to “be themselves.” While on occasion chaplains or other staff may explicitly support or counsel patients when they have religious or existential concerns, spiritual care is also understood as something that occurs in the course of a variety of mundane conversations and other activities. Its effectiveness also remains contingent on the motivations of the person extending it, rather than on the content of the care itself.

⁶³ Barbara Carroll also examines spiritual care in Britain to suggest that for most nurses the spiritual dimension permeates all forms of care. “A Phenomenological Exploration of the Nature of Spirituality and Spiritual Care,” *Mortality: Promoting the Interdisciplinary Study of Death and Dying* 6, no.1 (2001): 81-98.

In this chapter, I have further suggested that “spiritual care may be considered to have three dimensions: vocal care, resonating care, and supportive care. Vocal care refers to when spiritual caregivers converse and listen to patients while resonating care places an emphasis on simply *being* with the patient. Finally, supportive care refers to creating a hospice environment that helps the patient affirm their value in the midst of the dying process. This chapter has attempted to show the particularly key role that supportive care plays in the Japanese hospice. Whereas vocal and resonating care remain the central tenets of Japanese models of spiritual care that emphasize the need to help patients along in their journey to find “meaning,” in practice, supportive care also plays a very important role. Part of this gap between academic literature and practice can be attributed to the influence of the Western hospice movement on academic discussions of Japanese spiritual care. Academic concepts of spiritual care in Japan have borrowed heavily from a Western emphasis on religious and existential care based on a model of pastoral counseling. In practice, however, Japanese chaplains are quick to recognize that the cultural foundation for open discussion of religion and existential issues with patients who have never even heard of the word “spiritual care,” or view religious professionals suspiciously, is weak. Accordingly, spiritual caregivers first seek to develop a strong relationship with the patient in hope that after a level of trust is established, patients may feel more comfortable sharing their spiritual concerns. Or, in light of the fact that many patients appear disinclined or uninterested in bringing up such issues in the first place, spiritual caregivers may rely on simply showing patients how much they are valued. Either way, supportive care plays an important role in fostering an environment where patients feel comfortable and cared for.

This gap we find between the reified dimensions of personhood as articulated in Japanese academic literature on spiritual care and its apparent diffuseness in practice is also shaped by the

sensitivity hospice workers show to Japan's particular religious context. Since many Japanese view the work of religious professionals with suspicion, religious professionals have been able to draw boundaries around their work by delineating "spiritual care" from religion so as to legitimize their work. At the same time, they also emphasize what they bring to the hospice in terms of the religious training, which they claim makes them an existential anchor for patients. In this way, chaplains also use their presence in medical spaces to demonstrate the "healthy" role religion can play in Japanese society.

The reason supportive care plays such a key role in the hospice is also because it sits well with many contemporary Japanese, who typically express less concern than Western hospice patients might over religious questions of faith or belief.⁶⁴ While claiming that faith and belief are not an important issue for most Japanese runs the risk ignoring the experiences of many ardent Buddhist, Christian, or New Religious believers in Japan, in light of the relative lack of religious care in the Japanese hospice, it remains a valid point. Supportive care is also manifested through physical activities that help show the embodiment of spiritual care.⁶⁵ As shown in the diagrams of the previous chapter, Japanese hospice care literature often contrasts patient spirituality with their physicality or other aspects of being. But the practice of spiritual care in Japan lies in tension with the clinical classificatory impulse to distinguish between the spiritual and physical dimensions of care. For instance, one nurse described how she would often use foot

⁶⁴ John Traphagan, *The Practice of Concern: Ritual, Well-Being, and Aging in Rural Japan* (Durham, NC: Carolina Academic Press, 2004), 177; Reader, *Religion in Contemporary Japan*, 15-20; Ian Reader and George J. Tanabe, Jr., *Practically Religious: Worldly Benefits and the Common Religion of Japan*, (Honolulu: University of Hawai'i Press, 1998), 130.

⁶⁵ Just as philosophers of the mind have expanded the notion of our "minds" to show how its physical embodiment lies in tension with Cartesian assumptions, separating the "spiritual" from the way it is manifested in physical ways seems counterproductive. When we solve a difficult math problem is it really our mind or our hands (that is writing out the calculations or using an abacus) that is solving the problem? Clearly, it is both. For a detailed study of embodied cognition, see Sean Gallagher, *How the Body Shapes the Mind* (New York: Oxford University Press, 2005).

massages as a way to help patients open up in conversation. Likewise, chaplains heavily rely on events like tea gatherings where they sing songs and consume snacks as a way to engage patients in conversation and create further opportunities for them to share their spiritual concerns. In this way, chaplains and hospice staff often use supportive social events and physical activities such as tea gatherings and gardening as conduits for spiritual care.

Finally, this chapter has also revealed how chaplains sometimes feel a tension between normative images of spiritual care that are found in hospice care literature and what they actually do for hospice patients. While chaplains understood that the mundane companionship they provided patients was incredibly important for helping patients feel valued and supported, they also referred to examples of their interactions with patients who struggled with clear-cut existential or religious questions as more representative of the kind of spiritual care we find outlined in professional literature. This tension is also connected to the fact that most chaplains I interviewed were adamant that all patients experience spiritual pain—whether they express it outwardly or not. Although chaplains were by no means under the illusion that they alone had the skills to develop trust with patients and provide a comfortable space for patients to share their spiritual pain, many if not most felt that the reason spiritual care was conducted in the margins of other kinds of care was because hospice staff were not providing patients enough of a safe enough space to express their inner spiritual pain. The question of whether patients are simply unable to express their spiritual concerns in the hospice for cultural, religious, or practical reasons, or if there are simply fewer cases of spiritual concern at the end of life compared to more “belief”-oriented cultures, is thus a matter of ongoing tension between religious and secular hospice staff. This tension will be discussed in the next chapter, which shows how patients themselves narrate their concerns at the end of life.

As the funeral workers wheel the patient outside to the hearse, I join the hospice staff who quietly stream behind. When we exit the hospice doors, we are blinded for an instant by the bright sunlight, and I try not to sneeze. The patient is covered with a special quilt that was made by hospice volunteers. The workers take the quilt off the patient and replace it with their own blanket. Just as they lift up the quilt, the wind blows aside the sheet that was pulled over the patient's face, exposing her pale skin to the bright sun. The men quickly cover the patient's face, give an apologetic smile and hand the quilt back to the hospice staff.

The patient is loaded into the hearse and one of the funeral workers hands the bereaved husband his business card with a map to the funeral home on the back. The husband is unfamiliar with the location, but the worker reassures him by saying that he can just follow one of the other funeral workers who came in a separate car. The hearse leaves first, and as it pulls away, all the staff bow very deeply from the waist and keep their faces down parallel to the pavement until they are sure the hearse is out of sight. When I peek up prematurely, all I can see is the glare of the sun reflecting off the white rounded backs of the doctors and nurses in their uniforms.

After the hearse disappears from view, the husband turns to the staff and tries to say a few final words of thanks. Unable to gather his thoughts in words, instead, he bows deeply to the staff. We all bow back, rounding our backs again until his car is out of sight. When his car disappears from view there is a collective sigh of relief as the tension breaks. Staff turn to each other and murmur thanks for each other's help. There are even a few smiles as everyone strolls back to work.

Chapter Five

The Search for Spiritual Pain

Nakano Kōji 中野孝次 (1925-2004) was a Japanese professor of German literature, literary critic, and bestselling author who was diagnosed with esophageal cancer in February 2004. In his “Cancer Diary,” published posthumously by his wife, Nakano details his experience of being diagnosed with cancer, the headache of finding a good doctor, and his struggle over whether to pursue aggressive treatment to see if he could prolong his life. As he grew increasingly frail, he also mused on what it meant to live in the face of death.

I have a house and trees in my yard, my wife and dogs at my side. I have books and the four treasures of my study [brush, ink, ink stone, paper]. In my daily life, these are an extension of my person. Through all of these my life is made up. Lose any one of these and it is not my life. If these are cast away, where is my life? Without reading, writing, conversation, walking my dogs, and such, my life does not exist.¹

In these few lines, Nakano recognized that the meaning of his life was inextricably woven into the mundane; he did not look for the meaning of his life apart from or beyond his daily activities and relationships. His simple pleasures *were* his life.

Whereas the last chapter was focused on the ways caregivers offer spiritual care in hospice settings, this chapter will focus on the patient’s perspective and to what extent patients search for “meaning” at the end of life—something hospice workers like to call “spiritual pain.” For instance, if Nakano had entered a hospice, his increasing inability to walk his dogs might also have been diagnosed as a source of “spiritual pain.” As Cicely Saunders explained,

The realization that life is likely to end soon may well stimulate a desire to put first things first and to reach out to what is seen as true and valuable—and to give rise to feelings of

¹ Nakano Kōji, *Gan nikki: Nisen yonen nigatsu yōka yori sangatsu jūhachinichi nyūin made* (Tokyo: Bungei Shunjū, 2006), 83. This type of self-realization in one’s work, hobbies, family, or other relationships is often expressed in Japanese as a person’s *ikigai* 生き甲斐. See Gordon Matthews, *What Makes Life Worth Living? How Japanese and Americans Make Sense of Their Worlds* (Berkeley: University of California Press, 1996).

being unable or unworthy to do so. There may be bitter anger at the unfairness of what is happening, and at much of what has gone on before, and above all a desolating feeling of meaninglessness. Here lies, I believe, the essence of spiritual pain.²

In this passage, Saunders links the concept of spiritual pain to the “meaninglessness” that patients might feel when reflecting on their past, present, and future life. This focus on the patient’s search for “meaning” as a core aspect of spiritual pain is common in Western scholarship on spiritual care and is also seen in several of the Japanese models of spiritual care discussed in Chapter Three. For example, Japan’s hospice pioneer, Kashiwagi Tetsuo includes questions about “the meaning of life” or “the meaning of suffering” as central to spiritual pain, while Murata Hisayuki explained spiritual pain as “the pain caused by the extinction of being and meaning of the self.”³ In other words, as Nakano’s condition worsened and his daily routines were disrupted, the meaning and purpose that he drew from these lifelong routines were threatened. His life—as he previously knew it—could no longer exist.

Ultimately, this chapter will seek to uncover the extent to which Japanese hospice patients grapple with this “search for meaning” at the end of life. As the pages below will show, each hospice patient is different from the next. There is no common source of spiritual pain, nor is it always clear to caregivers what constitutes spiritual pain. Instead, as one might expect, Japanese hospice patients express a wide range of anxieties when facing the end of life—some explicitly existential or religious, mostly not.

² Saunders then goes on to discuss this “meaninglessness” at length (citing Viktor Frankl and the Book of Job) and also traces the “search for meaning” to the desire of many to “belong safely to something greater than our insecure and vulnerable selves.” Saunders, “Spiritual Pain,” *Contact* no. 122 (October 1991): 6-7.

³ Kashiwagi, *Shi ni yuku kanja*, 115-117; Hisayuki Murata, “Spiritual Pain and its Care in Patients with Terminal Cancer: Construction of a Conceptual Framework by Philosophical Approach,” *Palliative and Supportive Care* 1 (2003): 15-21.

As I draw on personal interviews with hospice patients, I will draw on my ethnographic fieldwork to introduce a very core tension that lies at the heart of the concept of “spiritual pain.” On the one hand, I suggest that for the majority of Japanese patients, spiritual pain is only rarely articulated in terms of a search for meaning, belief, or transcendence. In fact, many of the patients who come to “accept” their death claim to do so by letting go of the need to look beyond their condition altogether—a response to death that accords with the general reluctance of Japanese to turn to a particular religious tradition for soteriological guidance in life as well.⁴ On its face, the paucity of Japanese patients who raise questions about meaningfulness eviscerates notions of spiritual pain that are centered on what Saunders and others have called “the search for meaning.” As I will show, for many Japanese hospice patients, social and familial concerns often eclipse other existential or religious anxieties about the meaning of their life, suffering, or questions about what comes after death. In order to seek relief from the anxiety that they are a burden on others, instead, many patients try to fulfill their social and familial obligations until the very end of life. This confirms much of what was discussed in the previous chapter on how the practice of spiritual care in the Japanese hospice often goes beyond simply helping patients vocalize spiritual pain and addressing it through counseling or religious support. Rather, much of spiritual care is conducted in the margins of daily care, and allowing the patient to “be themselves” through special events or even prosaic activities—an affective (rather than cognitive) approach to spiritual care that elicits less resistance from non-religious patients. However, caring for these broader social needs that are integral to helping patients feel “like themselves” can also make it difficult for hospice workers to distinguish spiritual pain from more mundane needs. Like Nakano, deep reflexive questions by hospice patients about the meaning of

⁴ Toshimaro Ama, *Why Are the Japanese Non-Religious? Japanese Spirituality: Being Non-Religious in a Religious Culture* (Lanham, ML: University Press of America, 2005).

their lives are often embedded in more prosaic concerns. This has important ramifications for the practice of spiritual care since it makes it difficult for spiritual caregivers to distinguish between patients who might be experiencing some deep “spiritual” anxiety, and others who might—for example—be just having a bad day.

On the other side of this tension is the fact that hospice workers who are committed to providing spiritual care ultimately *do* suggest that a “search for meaning” can be latent, repressed, or sometimes just poorly articulated by Japanese patients. In their view, it is like a submarine at sea; even when you cannot see it, spiritual pain might be lurking below. This tension between the seeming absence and supposed presence of spiritual pain is significant for several reasons. First, speaking critically, this suggests that the discourse on spiritual pain in hospice settings may serve the needs of chaplains just as much as the needs of patients. For instance, the belief that every patient has some kind of spiritual pain offers an important way for chaplains to find value in their work and justify their profession to medical workers who may be reluctant to refer a patient to a chaplain or to even hire a chaplain to begin with. By framing even mundane concerns as potential signs of spiritual pain, chaplains are able to employ “strategically vague frames,” that bring a broad range of patient concerns under the purview of spiritual care.⁵ Although many chaplains recognize the arbitrariness of labels like “spiritual pain,” or have serious misgivings about the ways in which the concerns of patients are turned into a medical symptom by being labeled as an instance of spiritual *pain*, without the legitimization that the medical profession confers on their work, religious professionals would not be able work in the hospice in the first place.

⁵ Wendy Cadge, *Paging God*, 195.

From a more charitable perspective, this tension between the seeming absence and supposed presence of spiritual pain can also speak to a way in which spiritual pain in the Japanese hospice represents a very amorphous dimension of the patient's dying experience that eludes clinical detection. For example, chaplains sometimes flag the broader relational concerns patients have about being a burden on their families as marking the presence of a hidden inner form of spiritual pain. As we have seen in previous chapters, the terms "spirituality" and "spiritual care" function in Japanese hospice care as floating signifiers: they are available for the doctors, nurses, and chaplains who are committed to spiritual care to draw on to help make sense of and respond to any number of mundane and deep existential concerns that patients may express. Although patients would never put their own experiences in these exact terms, spiritual caregivers fall back on this label as shorthand to point to something they believe lies beneath the surface of their everyday interactions with patients. Those who are committed to the practice of spiritual care believe that the "spiritual pain" of patients is not something that they will naturally bring up with their doctor, like a "pain in my back," but is something that is often latent, subconscious, or even repressed. Since there is no single objective "sign" of spiritual pain, "sign-ification" is difficult. Instead, the symptom of "spiritual pain" is imputed to the patient by the act of typing those words into the patient's medical chart and by making a request for a chaplain to visit the patient. In other words, the label of "spiritual pain" is not an emic category but an etic category used by chaplains, doctors, and nurses, to capture certain dimensions of the patient's dying experience *through the work of care around* the patient. It is like a white circle

blending in on a blank piece of paper that only becomes visible by filling in the spaces around it.⁶

Stories from the Ward

This chapter will focus on three prominent themes that I drew from my conversations with patients as I asked them to describe the anxieties they felt toward death, what supported their *kokoro* the most at the end of life, and to what extent they drew support from religious beliefs or practices. These conversations with patients will also be supplemented by interviews with chaplains and other hospice staff who reflected on their past interactions with patients. Although I have tried to place my own interviews with patients at the center of this chapter, I believe it is important to confirm my findings with the accounts of hospice workers who have had years of uninhibited access to hundreds of patients. Hospice workers and especially chaplains are generally able to develop a much closer and trusting relationship with patients and their families than an outside interviewer.

The first theme I discuss is a strong desire by patients to not be a burden (*meiwaku* 迷惑) on others. This speaks to the social responsibilities felt by Japanese patients who worry about becoming a burden on their caregivers. The second theme is patient assertions that it is not worth worrying about the afterlife or pondering other deep existential questions, because these are things for which there were no clear answers. They were problems that could not be helped (*shikata ga nai* 仕方がない or *shiyō ga nai* 仕様がなない). After I discuss how these first two themes serve to call into question definitions of spiritual pain as representing a patient's "search

⁶ Or as Foucault notes, "diseases have no other reality than the order of their composition...In relation to the individual, concrete being, disease is merely a name; in relation to the isolated elements of which it is made up, it has all the rigorous architecture of a verbal designation. To ask what is the essence of a disease is like 'asking what is the nature of the essence of a word.'" *The Birth of the Clinic*, 118-119.

for meaning.” I will then consider how chaplains account for this tension between the seeming absence and supposed presence of spiritual pain in hospice patients. The third theme concerns acknowledgements on the part of some patients that finding something they could “hold on to” (*nani ka ni sugaru* 何かに縋る) relieves their anxieties at life’s end. For chaplains, such acknowledgements represent an important justification for their work, allowing them to draw explicitly on their religious training and background to help patients “transcend” their situation.

It should be noted at the outset that none of the three themes discussed in this chapter are unique to dying patients in Japan. For example, the fear of becoming a burden to others is known in the global parlance of hospice work as the patient’s “self-perceived burden” or “SPB.”⁷ Likewise, the patient view that death is inevitable and therefore not worth worrying about is certainly not unique to Japan.⁸ Finally, the idea that some patients can find relief by holding onto something, which might include belief in something transcendent, has been an important component of hospice care around the world since its founding. I note this broader comparative perspective at the beginning in order to clarify that my aim is not to delineate a unique Japanese “culture of dying.” As a matter of fact, many Japanese hospice patients have concerns and coping mechanisms similar to those held by patients from any number of other cultural contexts. My goal here is rather to show how difficult it is to pin down what “spiritual pain” refers to in

⁷ Natalie Cousineau, Ian McDowell, Steve Hotz, and Paul Hébert, “Measuring Chronic Patients’ Feelings of Being a Burden to their Caregivers: Development and Preliminary Validation of a Scale,” *Medical Care* 41 (2003): 110-118.

For studies on self-perceived burden in Japanese patients, see Akazawa et al., “Self-perceived Burden in Terminally Ill Cancer Patients: A Categorization of Care Strategies Based on Bereaved Family Members’ Perspectives,” *Journal of Pain and Symptom Management* 40, no. 2 (August 2010): 224-234; Miki Oeki, Tamiko Mogami, and Hiroshi Hagino, “Self-perceived Burden in Patients with Cancer: Scale Development and Descriptive Study,” *European Journal of Oncology Nursing* 16 (2012): 145-152.

⁸ Herman Feifel and Allan B. Branscomb, “Who’s Afraid of Death?” *Journal of Abnormal Psychology* 81, no.3 (1973): 282-288.

light of the emphasis Japanese patients place on social relations, the weak religious identity of many Japanese, and the relative paucity of patients who feel comfortable voicing deep anxieties to the chaplain or other hospice staff. These all make it challenging for hospice workers to circumscribe a coherent category of symptoms that might be diagnosed and commonly recognized as “spiritual pain.”

Methodology

All except one of the interviews presented in this chapter were conducted over a six-month period in 2015, at a Protestant hospice in Western Japan. Every week, I called the head nurse of this hospice to find out if any patients were available to be interviewed. Although I hoped to speak with several dozen patients, in the end, at this particular hospice, I was only able to interview eight. The lengths of interviews averaged between twenty to thirty minutes. One was only thirteen minutes and the longest was fifty-three minutes. All but two of the interviews were audio recorded. I also conversed informally with approximately two dozen more patients while conducting fieldwork at multiple Christian, Buddhist, and non-religious hospices in 2014-2015 and the summers of 2012, 2013, and 2017. I have included one of those patients (Mizuno-san) in this chapter.

The primary obstacle to gaining access to hospice patients in Japan was their physical condition. For formal interviews, I excluded all patients who had overt pain, difficulty talking, dementia, or who were emotionally unstable.⁹ This could mean that, for many weeks, no one

⁹ With recent advances in anti-cancer treatments that have fewer side effects, many patients and their families elect to pursue medical treatment until all options are exhausted or until the patient is exhausted. This means that many patients arrive at the hospice in a condition where having a normal conversation is nearly impossible. Even for those who are in relatively better condition, their level of pain and energy can fluctuate quickly.

was available to talk. During one week, I was told that not a single patient could eat, let alone talk, with an outside researcher. Patients could also suddenly take a bad turn. On one occasion, a patient agreed to be interviewed but then declined, just moments before I arrived. The practical and ethical challenges of gaining access to patients were most cogently driven home after I finished my first interview. During the interview the patient looked fine, could converse clearly, and was in very good spirits. When I arrived a week later, he was gone. I later found out that he had died the day after I interviewed him.

The interview and ethnographic data gathered in this chapter have several limitations. First, and foremost, due to the unique challenges I faced in gaining access to hospice patients, the sample size is small: in this chapter, I focus on seven patients. These patients represent individuals whom the hospice ward made available to me based on their willingness and ability to talk and are by no means “typical” hospice patients.¹⁰ Accordingly, I will not attempt to construct statistically significant claims about how Japanese hospice patients articulate their concerns at the end of life. However, it bears noting that even if the researcher were blessed with a rich set of data, creating a comprehensive typology of spiritual pain in Japan would remain a daunting task. As one veteran hospice physician liked to point out to me, if there are one hundred patients, they will die in one hundred ways.

On the other hand, the particularity of the case studies presented here has what Michael Burawoy calls “societal significance.” As Burawoy writes, “The importance of a single case lies in what it tells us about society as a whole rather than about the population of similar cases.”¹¹ In other words, the specificity of each patient’s experience also tells us something about the

¹⁰ The “average” patient was typically unavailable for interviewing because they were receiving heavy medication, were very weak, had dementia or were delirious, and could barely talk.

¹¹ Michael Burawoy, “The Extended Case Method,” in *Ethnography Unbound: Power and Resistance in the Modern Metropolis*, Michael Burawoy et al. (Berkeley: University of California Press, 1991), 281.

world in which they are embedded. Accordingly, the patients who are introduced in this chapter should not be viewed as representatives of wider patient types. Rather, each case highlights a notable feature of how hospice patients deal with death that helps us understand the cultural, social, and religious habitus shared by other patients as well.

I have also tried to refrain from psychoanalyzing patients, which is neither my goal nor something I am qualified to do. My approach is primarily one of qualitative description, where an encounter or event is described in everyday language without resorting to conceptual, philosophical, or other abstract frameworks.¹² This approach sometimes yields ambiguous, even contradictory findings and does not result in the sort of clear-cut conclusion that a firm theoretical commitment might offer. Nonetheless, I believe that my limited access to hospice patients made qualitative description the most suitable tool to use in this particular case.

A more significant challenge in interviewing patients, as I soon learned, was the fact that few if any patients were familiar with the word “spiritual” (*supirichuaru* スピリチュアル). If they were aware of it, they often associated it with ghosts and other paranormal phenomena. As a result, when explaining my research interests to patients, I could not ask them directly about the kinds of “spiritual pain” they experienced. This was liable to create confusion. Instead, I communicated to patients at the outset of each interview that I was interested in how the hospice provided *kokoro* care. Key questions I asked included: “What non-physical anxieties or worries do you have about death?” “What supports your *kokoro* the most?” “Do you feel supported by religion?” In some cases, family members were also present in the room. While this might have influenced the responses of patients, I used it as an opportunity to interview family members as

¹² Margarete Sandelowski, “Whatever happened to Qualitative Description?” *Research in Nursing and Health* 23, no.4 (2000): 336.

well. Sometimes my questions fell flat. Other times patients immediately grasped what I was interested in. The selections below represent what I believe to be the most lucid and direct responses to the key questions I posed.

The Fear of Being a Burden

Hara-san was in his late sixties and suffered from liver cancer. When I met him, he had been in the hospice for a little over a week. As I walked to his room with the head nurse, she mentioned that he took great pride in staying busy. He apparently felt that his wife and daughter were less capable than he was at taking care of the many household matters that had arisen in connection with his impending death. As he approached the end of his life, Hara-san felt that it was his responsibility to make sure that all necessary arrangements were being made for his family after he died.

(H=Hara, B=Benedict)

B. So, let's start.

H. Ask me anything.

B. First, could you explain a little bit about how you came to the hospice?

H. Do you need the specific dates or...

B. No, not at all. Just the gist...

H. In the middle of last month, I started to feel unwell.

(There is a knock at the door. A volunteer brings an afternoon snack).

B. So, in the middle of last month...

H. ...I started to feel unwell and I went to a local doctor who suggested that we look at my liver just to be sure. He then notified me that he could see a shadow in my liver. Not only that, it was a very large shadow. So before I came here, I was introduced to Hospital S. When I called the hospital and explained my symptoms, they said, "That sounds serious so please come right away to the hospital by taxi." At Hospital S, the doctor did many tests like CT, MRI, and ultrasound. After reviewing the results, the doctor said to me, "Hara-san, would you like to know the true details of your diagnosis, or would you like only your family to know, or would you rather not know anything and live peacefully? Which of these three options would you prefer? I told the doctor that I would like to know the truth and all the details. He asked me what I would like to know, and I said I wanted to know how long I had [to live] and what my symptoms would be. He said,

“Your life can no longer be saved. You are beyond receiving treatment since the cancer has proceeded into your bloodstream.”

(Eight seconds of silence)

“You probably have about three months left.”

Then I had him explain the symptoms properly. This was my wish. In the three months that remained, there were many things I could do for my family—things I did. I took care of my finances. I changed the *tatami* mats and took care of the piano. I haven’t finished the bathroom and bath yet, but I was able to make arrangements [for renovations]. As for renovating the house, I had ignored this for a long time because of the cost. I thought I would put it off until later. But I couldn’t wait any more, and so I called a company and we were able to make arrangements. We set up a plan. Well... I was hoping we could at least get an estimate and draw up a contract, but we just entered the rainy season.

B. Yes, it did rain yesterday.

H. During the rainy season, very few people request construction. The reason is because if it is humid when you are painting...

B. Ah... that can’t be good.

H. If the paint doesn’t dry properly, about three years later stains will appear. That’s why... but the thing is, you need scaffolding for painting. You need it to climb up and paint...

(His cell phone rings)

B. Please, go ahead.

H. No, I’ll turn it off. Hello? I’m being interviewed right now so I’ll call you later... yes (click).

H. Excuse me.

B. No, no, not at all.

H. And then...

B. The scaffolding...

H. The scaffolding costs ten thousand yen a day (about \$100). So then, if it starts to rain after they set up the scaffolding, the workers lose money. They need the scaffolding, but the cost is borne by the company. And so the company asked if I could wait until the rainy season ended and do the house renovations in August. Because of this, I don’t think there is enough time to finish the contract. But if the contract holder will not last until August, and the contract holder becomes a deceased person, all kinds of legal problems ensue. So we decided to put the contract in my wife’s name from the start.

(Five seconds of silence)

B. You have been making all kinds of preparations...

H. I have been most vigorously active! (Laughter)

B. You sure have!

H. Now... what was it I was meaning to say...um...

B. How you got to this point...

H. That’s right. So, as I accomplished these different things, the burden on my *kokoro* became lighter and lighter. So now, my mental state (*shinkyō* 心境) is such that I feel like I can die anytime. You see, I’m not afraid of death a single bit. Not a single bit. The only thing is...

(Five seconds of silence)

H. ...I don't want to die in a pitiful manner. For example, please excuse me for using the word "pitiable" (*nasakenai* 情けない) to describe this, but when you have something like a stroke, even if you survive, you can't communicate your intentions. You become a great burden on your family. This is why I'm glad I have cancer. With cancer, they tell you how long you have, and during this time, you can do all kinds of things. I'm in my late sixties, and I still have strength. My wife is several years younger and still has energy and physical strength. But if this happened five to six years from now, I wouldn't be so active, and even my wife would not have been able to move the way she can now. So I think all of this might have been the will of the god(s) I cannot see (*me ni mienai kamisama no omichibiki* 目に見えない神様のお導き). I am quite thankful. I'm very glad it turned out this way. The burden of my *kokoro* has become very light. My *kokoro* has become... it loses its desires and now it feels perfectly clear.

B. So, at first you felt that you needed to put things in order...

H. I was anxious. I had no leeway. So even when I was asked to do various things, I declined everything and just worked vigorously on household matters. After all, this is the most important thing.

B. I see, I definitely understand. So as you went about working on your home, the burden on your *kokoro* gradually lessened.

H. Yes, it lessened. I am now comfortable (*raku* 楽).

B. So, did you have any other particular kinds of worries (*fuan* 不安) or stress (*sutoresu* ストレス)?

H. Umm. Nothing for now. Well, there is the issue of my grave. My child is still single. She—I have a daughter—will be turning thirty-five, and so even if I buy a grave, she will not look after it forever, and so after thinking it over, I decided to be buried in a grave where many different people are buried together and memorialized. Oh, and I have already gotten an estimate from the funeral company (laughs). I have made every preparation possible! (laughs).

Hara-san's fear of becoming a burden on his family reflects the idealization of a certain manner of death in Japan. As Susan Orprett Long has demonstrated, two dominant cultural scripts for an ideal death in Japan are *rōsui* 老衰 (a gradual decline in old age), which provides time for the dying to arrange their family affairs and take care of loose ends, and *pokkuri* ポックリ (a sudden death), which does not impose the burden of a long hospitalization on the family.¹³

Notably, the idealization of these two very different types of death stems from the same

¹³ Long, *Final Days*, esp. chapter 4; Fleur Woss, "Pokkuri Temples and Aging," in *Religion and Society in Modern Japan*, Mark R. Mullins et al. eds. (Berkeley: Asian Humanities Press, 1993), 191-202.

rationale—a desire to not burden others. As Hara-san explained, his first priority was putting all of his affairs in order before he died. As he accomplished these goals that he had delayed for so long, the burden on his *kokoro* “became lighter and lighter.” It was clear that he derived satisfaction from tying up loose ends and making sure that his wife would not have to do them in his stead. He described these tasks to me with great pleasure, and our conversation was punctuated with laughter. He also felt that cancer allowed him to stay independent longer than other incapacitating illnesses. For example, he described his mother, who had been bedridden after having a stroke, as pitiable. He even thanked the “will of the god(s) we cannot see” for his cancer that allowed him to avoid this pitiable state. Finally, he explained that he had chosen to be buried at an eternal memorial grave (*eitai kuyōbo* 永代供養墓) instead of in a traditional temple plot.¹⁴ By choosing to be interred at an eternal memorial grave where Buddhist priests would perform memorialization rites for him on the behalf of family members, Hara-san further demonstrated that he did not want to place a burden on his family after his death.

Arita-san, who had stomach cancer and was in her late seventies, also described how entering the hospice had allowed her to avoid concern over becoming a burden on her family. During our interview, her daughter was also in attendance and chimed in with her thoughts.

(D=daughter, A=Arita, B=Benedict)

D: I was taking care of my mother at home with the help of a home doctor, nurses, and caregivers, but my mother kept saying, “I’m sorry, I’m sorry [for being a burden]” (*mōshiwakenai, mōshiwakenai* 申し訳ない、申し訳ない).

A: Being at home was emotionally difficult...

D: I was glad I could show respect to my mother (*oya kōkō* 親孝行) by helping her and planned to keep doing so, but my mother is sensitive (*ki o tsukau* 気を使う) [about

¹⁴ Eternal memorial graves represent a relatively new form of communal ossuaries where memorialization rites are conducted by a third party (instead of by living family members) for those who are buried there. This increasingly popular form of burial is cheaper than purchasing an individual plot at a temple and ensures that the deceased will continue to be memorialized without placing a burden of obligation on surviving family members. See Rowe, *Bonds of the Dead*.

being a burden]. She is even sensitive with the nurses. When a nurse comes, she feels that she needs to do whatever it is quickly since they are so busy... When I was at home, I would sleep next to her, but sometimes I would wake up in the morning and my mother would tell me her pajamas had gotten soiled. She asked me to wash them, and I asked, “How did you take them off?” I found out that [instead of waking me], she had struggled to take them off herself. I would say, “Wake me up! That’s why I’m living here with you.” (Laughs)

The prevalence of Japanese patients who cite being a burden on their family, friends, and caregivers as a key concern at the end of life is not surprising. This is also borne out in ethnographic work conducted by Long, which details the multiplicity of cultural scripts that both Japanese hospice patients and caregivers avail themselves of at the end of life. These scripts include acknowledgement of the responsibilities and burdens that accompany social relations, such as being a “burden” on caregivers, and the importance of having family members present at the time of death (*shinime ni au* 死に目に会う).¹⁵ Although slightly removed from the hospice context, similar ethnographic work on the lives of the elderly in Japan by John Traphagan also suggests that the anxiety by Japanese elders over becoming a burden on their families and communities is one of the key reasons for Japan’s extremely high rate of elder suicide.¹⁶

Several surveys of terminally ill patients conducted by hospice physicians and nurses in Japan have suggested that this self-perceived burden can also be considered as a form of spiritual pain. For example, one study of eleven Japanese hospice patients highlights as examples of spiritual pain such expressions on the part of patients as, “I want to die before I become a burden

¹⁵ Long, *Final Days*, 60-61.

¹⁶ John Traphagan, “Generations Apart: Burdens, Bad Families, and Elder Suicide in Rural Japan,” in *Faces of Aging: The Lived Experiences of the Elderly in Japan*, ed. Yoshiko Matsumoto (Stanford: Stanford University Press, 2011), 101. About a third of Japanese terminally ill cancer patients also express a desire to die or that death be hastened. Tatsuya Morita, et al., “Desire for Death and Requests to Hasten Death of Japanese Terminally Ill Cancer Patients Receiving Specialized Inpatient Palliative Care,” *Journal of Pain and Symptom Management* 27, no 1 (January 2004): 4-52.

on others,” or not wanting to be a “I don’t want to cause anxiety and trouble to my husband.”¹⁷ A larger-scale survey by Morita Tatsuya, a hospice physician and leader in Japanese hospice care research, identifies seven categories for existential pain (*jitsuzonteki itami* 実存的痛み) a term used as a synonym for spiritual pain.

Table 1. Existential concerns of terminally ill Japanese cancer patients¹⁸

Acceptance/preparation	25%
Relationship-related concerns	22%
Isolation	
Concerns about family preparation	
Conflicts in relationship	
Hope/hopelessness	17%
Loss of control	16%
Physical control (dependency)	
Cognitive control	
Control over future (uncertainty)	
Loss of continuity	10%
Loss of role	
Loss of enjoyable activity	
Loss of being oneself	
Uncompleted life task	6.8%
Burden on others	4.5%

According to Morita, about a quarter of the eighty-eight patients interviewed expressed an existential form of pain related to a general unpreparedness for death, while—as indicated at the very bottom of the chart—just under five percent of patients directly expressed a fear of becoming a burden on others. While the number of patients who fear being a burden on others seems low in this survey, this is due in part to the way the categories were set up. For example, 16% of the patients surveyed expressed concern about loss of control over their faculties, while another 6.8% of patients were worried about tasks left uncompleted, such as legal matters or funerary arrangements. These patients were likely anxious, as Hara-san was, that such factors

¹⁷ Kawa Masako et al., “Distress of Inpatients with Terminal Cancer in Japanese Palliative Care Units: From the Viewpoint of Spirituality,” *Support Care Cancer* 11 (2003): 485.

¹⁸ Reproduced from Morita et al., “Existential Concerns,” 138.

would add to the burden they already saw themselves as posing for others. In addition, 22% of patients in Morita's survey also indicated relationship-related "existential pain" that included expressions of concern about their family's preparation for their death. In effect, several of these categories could arguably be seen as expressions of concern about becoming a burden to immediate family members.

The extraction of a patient's self-perceived burden as a category of spiritual pain that is based on statements made about ultimate concerns at the end of life stands in contrast to the United States. For example, a widely used survey on spiritual well-being used in North American hospice settings called the FACIT-Sp contains twelve questions that asks patients to rate their feelings of inner peace, purpose, harmony, and meaning, as well as strength or comfort from religious or spiritual beliefs, but does not address the question of being a burden on caregivers. This is not because American hospice patients do not worry about becoming a burden on others (they certainly do), but because these types of concern are not considered as "spiritual" in nature. The view by Japanese hospice workers that fear of being a burden is a form of spiritual pain could certainly makes sense given the cultural importance placed on repaying social debts (*on* 恩) and fulfilling obligations (*giri* 義理). An inability to repay such debts could conceivably cause deep anxiety for patients to whom the fulfillment of these obligations might give meaning, thus causing "spiritual pain."

However, identification of the patient's "self-perceived burden" as a form of spiritual pain also raises questions. For example, it is not entirely clear how such anxieties might differ from the concerns social workers or clinical psychologists on the hospice team are trained to deal with. Although the fear of being a burden on others could certainly bring patients to examine existential questions about the meaning and value of their life, such anxieties can also be more

generic expressions of concern by patients who care deeply about their families and simply wish to not burden them.¹⁹ In this way, patient expressions of self-perceived burden cannot escape a fundamental interpretive ambiguity, in that they can be understood either as natural reactions to becoming dependent on others, or as signifying a deeper existential insecurity in the face of approaching death.

It Cannot Be Helped

In my own interviews with patients, another reason many patients suggested that existential questions about meaning or purpose, or the afterlife, were not an outright concern for them, was because they saw death as inevitable, and that worrying about it would not change anything. Patients described such questions as *shiyō ga nai* 仕様がない or *shikata ga nai* 仕方がない (lit. there is no way [to solve it]). For example, our friend Hara-san, who was busy tying up loose ends, had this to say when I asked him why he did not worry about death.

B. Before, you said that you were not afraid of death at all...

H. Not at all. I've never feared it one bit.

B. I see. That is remarkable.

H. As I said earlier, the only thing I feared was having a stroke or dying in a way that made me a burden (*meiwaku*) on others. I feared this before I became ill with this disease. I especially feared having a stroke, because that was how my mother died. She was restricted to her bed, and we couldn't understand her words. Since we were family, we could understand a little bit, but for the doctors and for herself, I think it was very painful. She couldn't get up, and she couldn't even turn over in her sleep. I think it was painful for her just to be living. You might even say, and I probably shouldn't say this, it was like being tortured before death (laughs). Anyway, it was torture for her, and it was a great

¹⁹ One question to consider for future research is whether this concern is particular to hospice care wards or also applies to terminally ill patients who die in other settings like home hospice. It would appear that most Japanese who are concerned about being a burden on caregivers prefer to die in a palliative care ward rather than rely on family members for end of life care. Sakiko Fukui, Junko Fujita, and Kazuhiro Yoshiuchi, "Associations between Japanese People's Concern about Family Caregiver Burden and Preference for End-of-Life Care Location," *Journal of Palliative Care* 29, no.1 (2013): 22-28.

burden on the family. To think that I can go without this, I thank the gods (*kami ni kansha shiteimasu* 神に感謝しています). Cancer is a wonderful disease (laughs).

B. That is wonderful that you can be so positive. For example, some patients may fear what comes after death, or have similar kinds of anxiety... I hear this from time to time but in your case you don't seem to...

H. In my case, concerning the afterlife, since I have never gone there, I don't know. So, I believe there really is no point (*shikata ga nai* 仕方がない) to think about this. The only thing is, at the funeral, even if you have a grand funeral, many people will just talk about their business lives or catch up [with friends]. There are grand funerals where the deceased is not mourned, and there are also small funerals where the deceased is truly mourned from the *kokoro*. This is determined by one's actions while living. That is why I think that perhaps one's actions while living might be reflected in the afterlife—reflected in the *kokoro* of those who are left behind.

Here, Hara-san suggests that his only real fear was dying in a way that would cause him to be a burden on his family. With vivid memories of his own mother's suffering after having a stroke, he is once again thankful to the gods that he can avoid such "torture." When I asked him about his view of the afterlife, he dismissed any such worries. As he explained, nobody has experienced the afterlife and lived to tell about it, and so there was no point in thinking about it (*kangaetemo shikata ga nai* 考えても仕方がない). As far as he was concerned, the only afterlife he could control was how he would be remembered in the *kokoro* of those he left behind.

This stoic view of death was also reflected in my conversation with Yanagi-san, another patient who claimed death did not cause him any real concern. Yanagi-san was in his mid-seventies and had been struggling with stomach cancer for several years. According to the nurse, he was looking forward to talking with me. Later, I learned that our conversation was a virtual repetition of what he had spoken about with the chaplain earlier in the week. He had a piece to say and was looking to share it with anybody who was willing to listen. When I entered his room, he was watching TV while lying on his bed in his pajamas.

Y. I've really become amiable (*nagoyaka* 和やか), and I don't fear death anymore.

Not at all. So even if I died today or tomorrow, I don't fear anything at all. I thought that I might be a little fearful at night when I'm all alone in the dark, but this didn't happen either.

B. You didn't fear death in the past either?

Y. No, no, I was a real scaredy cat.

Yanagi-san then began talking about how his illness had helped mitigate his fear of death. He pointed out that being forced to interact with many different people through his illness had made him a better listener. He admitted that he had originally been short tempered and would fight with his wife. But since being diagnosed with cancer, he had become a more understanding person. I tried to draw him back to his claim that he didn't fear death.

B. But in regard to death...

Y. So in regard to [my not fearing] illness or death, I want to turn the question to you.

How is it that I have become like this? I almost want you to point this out to me.

B. Some patients say that they are fearful of suffering at the end or of whether there is an afterlife...

Y. You just need to make your own story (*monogatari* 物語). Leaving aside the question of whether this is a right or wrong approach, since I haven't been to the afterlife, nor returned from it, ultimately, I think it is fine to imagine for yourself what it might look like. That's what I plan to do. When this life is over, I believe there is a spirit world (*reikai* 霊界) somewhere in heaven where everyone is gathered. People from Europe, the Americas, and other places must all pass through this spirit world. The spirit world is a place of only spirits (*tamashii* 魂). Since there are no human bodies and just spirits, you don't need English or German or anything; everyone just speaks "spirit world-ish" (laughs)... Everyone will meet above the earth, and I'm sure there will be those who did some slightly bad things. But everyone just studies (*benkyō shite* 勉強して) and after polishing themselves (*migaite* 磨いて), a few years later they come back over here [to earth]. So you see, I've never done religion or anything like that, but since this is what I think and plan to do, I don't have anything to fear...ultimately, saying that you are afraid because you don't know whether you will go to heaven doesn't help (*ittatte shiyōganai* 言たって仕様が無い). You just need to think for yourself and make up your own ideal [explanation].

As I prodded Yanagi-san on whether death inspired any fear in him, he suggested that while in the past had thought that he might fear death, he no longer had such concerns. In fact, in regard to the afterlife, he had his own theory that all humans would be taken to a supernatural realm

where they could study to be better people before being reborn into this world. He did not claim that his theory was for everyone. Instead, he thought that each person should make a story of their own liking to help mitigate fear of their postmortem fate.

Both Hara-san and Yanagi-san suggested that worrying about their postmortem fate was a futile exercise. After all, no one really knows what lies beyond death. However, in contrast to Hara-san, Yanagi-san had clearly devoted some time to thinking about this. Whereas Hara-san was more interested in discussing what he could control in terms of how he might be remembered by his family, Yanagi-san described this own theory about the afterlife with great gusto. It was less clear why—if he was truly unconcerned about death—he felt the need to create his own narrative of the afterlife. The fact that Yanagi-san had devoted some thought to this issue, and was eager to share this theory with both the hospital chaplain and myself seemed to indicate that while convinced that there was no point in worrying about what lay beyond death, that had not stopped him from thinking about it.

Corroboration from Chaplains

When I inquired of hospital chaplains whether their experience tallied with my impressions that many patients seemed, at least on the surface, indifferent to religious or existential questions in the face of death, several readily agreed. One chaplain at a hospital in Tokyo put it this way:

In terms of spiritual pain, in my experience, most patients do not have large anxieties (*fuan* 不安). Instead, they mostly just talk indifferently about themselves (*tan tan to hanasu* 淡々と話す). It is hard to say if they have come to accept their death. Japanese are very ordered about these things. Many patients choose not to think about it and say it can't be helped (*shikata ga nai*). They have made this their policy from the beginning. They see no point in worrying about it. In this regard, many patients do not have much

inner conflict (*kattō* 葛藤). This point is driven home when we occasionally have Korean or Chinese patients. They are much more emotionally involved.²⁰

Another chaplain put it more bluntly:

Japanese are very good at giving up (*akirameru no ga jōzu* 諦めるのが上手). For example, Kübler-Ross's model [of the five stages of grief] does not fit very well with Japan. For most Japanese, the final stage is not acceptance (*juyō* 受容) but giving up (*akirame* 諦め). They all say, "It can't be helped" (*shiyō ga nai*). They do not try to figure things out. Many Japanese do not think so philosophically about these things. They will just say, "Such is life" (*jinsei wa sōyū mono ja nai ka* 人生はそうゆうものじゃないか).²¹

When I asked yet a third chaplain what he thought of the notion that Japanese are "good at giving up," he began nodding vigorously:

Yes! Yes! That makes perfect sense. You know patients will change (*kirikaeru* 切り替える) [at the end of life]! I think Japanese place a value on quitting, on seeing death itself as an end....For example, the suicide rate is high too. This is not the same as the Buddhist understanding of non-attachment; it is rather about not wanting anything and throwing away everything. There are many elderly [patients] in their seventies and eighties. They won't say a peep. They probably didn't live during a time where you thought a lot about the meaning of life or the meaning of death. It was Japan's period of economic growth. Housewives were immersed in the practical matters of day-to-day living and made great sacrifices for their family. When their body finally stops working, they accept it. It is the same for the men. When they lose, it is over.²²

According to the first chaplain, very few patients voice large existential or religious anxieties. Or, at least, many patients choose to not dwell on anxieties that "cannot be helped." According to the explanations proffered by these last two chaplains, this ostensible lack of spiritual pain in Japanese hospice patients is also partly due to a kind of stoicism in elderly patients of a certain generation, if not all Japanese. In particular, the last chaplain saw patients who lived through the Shōwa 昭和 period (1926-1989) as a stoic generation that survived the political and economic

²⁰ Personal Interview, May 18, 2015.

²¹ Personal Interview, March 25, 2015.

²² Personal Interview, May 5, 2015.

turmoil of the Second World War and its aftermath and then worked tirelessly through the economic boom that followed the 1960s. According to this chaplain's narrative, many Japanese salary men were simply conditioned not to think (or were too busy to think) about the deeper meaning behind their overworked lives. Likewise, the chaplain believed that Japanese housewives, who were pressured to sacrifice their careers after marriage and toil at home for their husband and children, were conditioned to accept the unfairness of the gendered social status quo. In this chaplain's view, these cultural experiences generally helped prepare Showa-generation patients to accept with equanimity the sufferings that came with dying of cancer.²³

Notably, while the last chaplain's made a point of distinguishing between the tendency for patients to "give up" difficult questions at the end of life and Buddhist ideas of non-attachment, yet another chaplain suggested to me that the resignation he often saw in patients could stem from Buddhist influence. He shared a story to me of a married female patient in her early fifties who still had young children, and in his view, had "lost hope." She explained to him, however, that she had lived her life with "resignation" (*teikan no omoi de ikite kimashita* 諦観の思いで生きてきました).²⁴ He noted that this idea of "resignation" (*teikan* or *taikan* 諦観) is central to Buddhism in which it means to "see clearly" (Skt. *Darśana*).²⁵ In fact, the Japanese word *akirame*, or to "give up," actually stems from this Buddhist sense of the term, "to make clear" (*akiramu* 明らむ). This helps explain the positive tenor of the claim "Japanese are

²³ Importantly, this last chaplain was not suggesting that most Japanese patients did not have spiritual pain at all. On the contrary, he pointed out later in the interview that the seeming lack of spiritual pain could also be chalked down to the private nature of his patients (especially in the Tokyo area where he worked). He imagined a patient saying, "Why would I talk to a minister?"

²⁴ Personal interview, May 7, 2013.

²⁵ Nakamura Hajime, *Kōseitsu bukkyōgo daijiten* (Tokyo: Tokyo Shoseki Kabushikigaisha, 2001), 1106.

very good at giving up,” since “giving up” (*akirame*) and “making clear” (*akiramu*) are etymologically linked.

These chaplains’ accounts, surveys administered by hospice doctors and nurses seeking to measure spiritual pain, and my own interviews with patients suggest that, for many Japanese, facing death does not necessarily prompt outward expressions of deep spiritual anxiety to those who are caring for them. For example, Morita’s survey on existential pain, touched on earlier, suggests that the search for meaning is not necessarily the most important “existential” issue that can be detected in Japanese hospice patients. Of the seven categories that Morita established, only two, “hopelessness” and “acceptance,” seem directly tied to patient concerns over whether their life has been meaningful, the meaning of their current condition, or what meaning is left in the remainder of their life, which is commonly assumed by Western spiritual care practitioners to be important components of spiritual pain.²⁶ On closer examination, however, even these connections prove tenuous. For example, in Morita’s survey, expressions of “hope/hopelessness” included patients who looked forward to or worried about family concerns, such as whether they would survive to see the “completion of a new house, birth of a child, the ballet performance of a grandchild” or embraced hopes of “returning home and curing the disease.” Likewise, anxiety about acceptance of death typically included very general expressions of concern such as “I don’t want to die” or “I fear that I am going to die.”²⁷ While such statements could signal deep existential fears, they are also quite vague and could refer to any number of non-existential

²⁶ See Saunders explanation of spiritual pain in the opening section of this chapter. See also Ingrid BolmsJo, “Existential Issues in Palliative Care—Interviews with Cancer Patients,” *Journal of Palliative Care* 16, no. 2 (2000): 20-24; and Alyson Moadel et al., “Seeking Meaning and Hope: Self-Reported Spiritual and Existential Needs Among an Ethnically-Diverse Cancer Patient Population,” *Psycho-Oncology* 8 (1999): 378–385.

²⁷ Morita et al., “Existential Concerns,” 139.

concerns, such as the fear of physical pain at the end of life, or disappointment of a patient over not being able to meet his or her future grandchildren.

Taken together, these results suggest that very few Japanese hospice patients outwardly express existential questions about the meaning of their life or suffering, or what may lie in store after death. However, before we attribute this to some specifically Japanese culturally determined stoicism as some of the chaplains I spoke to did, it is worth noting that there are good indications that death anxiety may be less prevalent than one might expect outside of Japan as well. For example, Jonathan Jong and Jamin Halberstadt argue that in the United States there is little evidence to suggest that the proximity of death will heighten one's anxieties about it—at least not at a conscious level.²⁸ In fact, one study of ninety-two terminally ill patients showed them to be less fearful of death than healthy individuals.²⁹ One explanation for this is that many hospice patients come to see death as inevitable. As Jong and Halberstadt point out:

By far the most common reason given for their lack of fear was that death is inevitable. This is somewhat ironic given that many thanotocentric theories and Terror Management Theory in particular cite this exact aspect of death—its inevitability—as a prime reason to fear it... terminally ill and seriously ill participants likely appreciate the inevitability of death better than most, and yet they seem to have the opposite response: It's going to happen, so why worry?³⁰

This suggests that the infrequency of strong death anxiety amongst hospice patients may not be limited to Japan. While exploring the comparative aspects of death anxiety around the world exceeds the scope of this study, it is critical to note this comparative context to emphasize that

²⁸ Jonathan Jong and Jamin Halberstadt, *Death Anxiety and Religious Belief: An Existential Psychology of Religion* (New York: Bloomsbury, 2016), 105.

²⁹ Herman Feifel, "Religious Conviction and Fear of Death among the Healthy and the Terminally Ill," *Journal for the Scientific Study of Religion* 13, no. 3 (1974): 353-360; Feifel and Branscomb, "Who's Afraid of Death?"

³⁰ Jong and Halberstadt, *Death Anxiety*, 104-105. By "terror-management theory," Jong and Halberstadt refer to a theory that argues that since humans are aware of their own mortality, this creates existential anxiety, which is dealt with by seeking either literal or symbolic immortality. *Ibid.*, 40.

Japanese hospice patients are not conditioned by some “samurai-like” stoicism that makes them oblivious to the fear of death. Rather, these findings simply suggest that studying the minimal degree to which Japanese patients raise existential questions about “meaning” at the end of life may also have important cross-cultural implications for the study of care of the dying.

As my interviews with patients and chaplains showed, patients are often concerned about being a burden on their family and tend to deflect existential questions about the “meaning” of their life or suffering with the understanding that these are issues “they cannot be helped.” Surveys also indicate that patients do not believe religious faith is important in order to have a good death.³¹ Although some chaplains suggested that a cultural stoicism might help explain why patients rarely voice existential or religious concerns, the relative lack of death anxiety amongst the dying in other cultural contexts suggests that other factors are also in play. In the next section I will examine the explanations proffered by chaplains who suggest that sometimes you have to “dig” for spiritual pain.

Digging for Spiritual Pain

As the previous sections have suggested, it appears that Japanese hospice patients only infrequently articulate deep existential or spiritual questions about meaningfulness, guilt, their relationship with some transcendent power, or anxiety about the afterlife. But if this is the case, we must ask: given the lack of religious or even existential concerns expressed by the majority of Japanese hospice patients, how necessary are chaplains? What role does the religious specialist play on the hospice team? Could a clinical psychologist, counselor, or volunteer just as adequately treat patients concerns? More importantly, what does this say about the other side of

³¹ Kei Hirai et al., “Good Death in Japanese Cancer Care: A Qualitative Study,” *Journal of Pain and Symptom Management* 31, no. 2 (February 2006): 144

the core tension in spiritual pain: namely, the strong insistence by chaplains, nurses, and doctors who are committed to spiritual care, that such care for patients should not only be available, but is indispensable to caring for most if not all patients?

One suggestion offered by some chaplains to explain the lack of “spiritual pain” is that patients may be simply denying or suppressing their death anxiety. In other words, although patients may not be fully conscious of their inner anxieties, they may still have them anyway.³² This is a crucial point that gets to the core of the tension in the study of “spiritual pain”: if the patient is not expressing spiritual pain, what need is there for spiritual care? To take the case of Yanagi-san, who claimed that he was not afraid of death at all, a spiritual caregiver might argue that Yanagi-san might nonetheless be experiencing some sort of spiritual pain at the subconscious level—a form of spiritual pain that did not manifest itself through observable symptoms. As a matter of fact, despite the fact that Yanagi-san claimed that he did not “fear death,” he was also strangely insistent that patients should set about creating their own narrative about the afterlife to achieve peace of mind. Might this not actually indicate some level of concern about his postmortem fate? On the other hand, if Yanagi-san himself claimed to be unconcerned about death, could his experience still be called spiritual *pain*? Even assuming that he was secretly concerned, when a patient has successfully coped with these concerns in his or her own way, on what grounds could a hospice worker claim that such a patient was in need of spiritual care?

Most of the Buddhist and Christian chaplains I spoke with in Japan believed that whether they expressed it outwardly or not, most hospice patients experienced some degree of spiritual

³² This actually echoes some studies that suggest that while conscious or overt levels of death anxiety may be low in terminally ill patients, unconscious or covert anxieties can become slightly heightened with proximity to death. Feifel, “Religious Conviction.” See also Bert Hayslip Jr. et al., “Levels of Death Anxiety in Terminally Ill Persons: A Cross Validation and Extension,” *Omega* 34, no. 3 (1997): 203-217.

pain deep inside. Although chaplains admitted that only a handful of patients might openly display concern about meaning, guilt, or the afterlife, they also firmly believed that this indifference was only the patient's public face and that in many cases, they might be overlooking a hidden spiritual pain. In short, they expected that patients, and especially those of an older generation would stoically repress their spiritual pain by claiming, "It can't be helped." As one chaplain explained to me, sometimes you have to dig for spiritual pain:

Sometimes I will ask a patient if they have any anxiety and they will respond, not really. But then I will start talking about things I might feel anxious about [in their place] and they will say, "Yes, me too!" Some patients will even laugh and say, "Oops! I did not mean to share that!"

You have to look for it; patients won't bring it to you. You have to dig around by asking about their condition, family, history, and hobbies and so forth before it comes out. I tell nurses to make sure they make the conversation fun, because it is a lot of work to uncover. You need to make sure the patient is enjoying the conversation.

Many patients will basically say they don't have any worries in particular, but when they say no, it doesn't always mean no. In the United States, they will keep passing you the mashed potatoes until you say, "No thank you," and then they won't offer it to you anymore. But in Japan, you need to keep offering it even after they say, "No, thank you." to make sure they aren't just being reserved (*enryo* 遠慮). I sometimes will tell the patient, "You may not have any worries now, but if you do in the future, make sure that *you* call me. That way, the responsibility lies with the patient."³³

As this chaplain explained, in Japan, patients are more likely to hide their true feelings. This means that chaplains cannot simply assume that an outwardly placid patient may not be working through some difficult questions. However, although this particular chaplain insisted that patients needed to be prodded to share their deep anxieties, she was also careful to point out that, in the enthusiasm for instituting spiritual care in Japanese hospices, there was also a very strong danger in trying to see spiritual pain where there was none:

³³ Personal Interview, March 25, 2015.

Everyone wants to talk about how Japan is behind in providing spiritual care. They throw everything under the label of spiritual care. I think it would be great to have a presentation at a conference that talked about cases where they thought the patient was experiencing spiritual pain but it turned out to be something totally different. I think everyone would get a kick out of that. Maybe a [hypothetical] patient was anxious about dying, but after inheriting a large amount of money, all of a sudden, he or she stops worrying (laughs)! [Cicely] Saunders was trying to emphasize the concept of total pain. We can't just take the spiritual part out and emphasize it. Sometimes the patient is just in pain. "Doctor, please give him some more medication!" It can be as simple as that.

I remember one patient whose grandson was competing in the national high school baseball tournament. The patient said that if the grandson's team made it to the finals, he really wanted to go watch. He could still walk, and so the whole hospice staff was cheering for the team to make it to the finals. The team was doing well, but shortly before the finals, the patient's cancer spread to his bones. He could no longer get up on his own. After the doctor explained his condition to him, he said he would just watch the finals on television. After this, he asked for a nurse to bring him his drawing materials and went about his hobby in an unperturbed manner.

But his nurse was very concerned that he might be feeling some spiritual pain due to this [not being able to attend the game] and kept checking in on him. She told the rest of the staff that she thought he might be trying hard to remain stoic in the face of great disappointment. However, I was a little suspicious and thought it would be better to just ask the patient directly. I went and asked him directly how he felt after receiving such bad news. I also mentioned that the staff was worried that he was trying to hold in his disappointment. He laughed and said, "Oh, so that's why the nurse keeps checking in on me!" He then clarified his stoic reaction: "I'll explain why I'm not expressing anything. I am a Tenrikyō believer, and this supports me. My *kokoro* doesn't easily become disturbed as others might expect. I don't think I will become like other patients."

As these stories show, assessing spiritual pain is a delicate task. A times patients might be reluctant to share their anxieties with the staff whose job is to support them. At other times, nurses or chaplains who are looking to provide spiritual care might be looking for spiritual pain where there is none. The Tenrikyō patient for example, flatly denied that he was hiding spiritual pain.³⁴ Instead, he credited his stoic reaction to his personal faith, which kept his *kokoro* from being disturbed.

³⁴ Tenrikyō 天理教, is a Japanese new religion founded in the mid-nineteenth century by Nakayama Miki 中山みき (1798-1887).

In rare cases, an overzealous staff member could actually worsen the patient's condition by trying to probe for spiritual pain. For example, a palliative care nurse who worked at a large hospital near Tokyo shared the following story.

At the palliative care ward where I previously worked, there was one staff member who felt a very strong need to provide spiritual care to patients. But in one case it made things difficult for a patient who was not seeking this type of care. I sometimes wonder if one should try not to be too sensitive about spiritual care; it sometimes feels like the medical worker is jumping to conclusions... I understand that the goal of saying you need to do this or that, and to make a manual for spiritual care is to make everyone more conscious about spiritual care and to help the many people who do not know how to provide it. But this staff member got caught up in practicing this and forced the patient to confront questions such as, "Why did you get ill?" "Why are you here?" After being confronted with these questions, the patient became depressed and there was nothing we could do to help. The patient stopped eating, refused all treatments, and died about a week later.³⁵

This last anecdote demonstrates the care and sensitivity required by chaplains and other hospice staff who are involved in spiritual care. On one hand, spiritual pain is not something that patients will necessarily bring up themselves. For example, chaplains and staff pointed out to me that relatively young patients, who might still have young children or living parents could be reluctant to discuss their spiritual pain because they did not want others to feel sorry for them. Patients of an older generation who adhere to more traditional values might also be reticent to share personal matters with an outsider. Sometimes gender could also play a role. One chaplain jokingly mentioned that if there was a patient who refused to see a chaplain, it was almost always a male in his early fifties.³⁶

On the other hand, inexperienced digging for spiritual pain can make matters worse. Or at best, the spiritual caregiver might be barking up the wrong tree. The Tenrikyō believer claimed that his faith allowed him to not become discouraged in the face of his faltering health. Hara-san who was busy changing the *tatami* mats and painting his house claimed that the burden on his

³⁵ Personal Interview, May 21, 2015.

³⁶ Personal Interview, May 18, 2015.

kokoro had become “lighter” by making arrangements for his family, and Yanagi-san, who had his own theory of what lay beyond death, claimed that he didn’t fear death at all. Such patients might not be experiencing what hospice workers define as spiritual concerns. But at the same time, some hospice workers insist that this seeming assurance does not necessarily mean that such patients are without spiritual pain or are not grappling at all with religious or existential questions. For example, a Protestant chaplain related the following story.

I had one male patient who was fifty-nine years old. He told me that he only “believed in himself” (*jibun o shinjiru* 自分を信じる). However, he respected the fact that I was a Christian and enjoyed my coming to visit him. He never indicated in any way that he was personally interested in Christianity. But as his sickness proceeded, I heard from his wife that one time he was sleeping in his bed when he raised his arms up, saying “I’m sinking, I’m sinking!” When I heard this, I think that even he must have reached his limit (*genkai* 限界); he realized that he couldn’t help himself in the end. I would often share with him quotes from Hoshino Tomihiro’s books and Bible verses to encourage him.³⁷ After he passed away, his wife showed me his journal that he kept by his pillow. He had recorded the quotes from Hoshino as well as some Bible verses. You can never tell what lies in a patient’s *kokoro*.

When I asked another Catholic chaplain what she thought of patients who said that there was no point dwelling on unanswerable existential questions since they “cannot be helped,” she told me that these were simply excuses. “It may also mean that they don’t feel comfortable talking about it with you or whomever. When a patient says that ‘it can’t be helped,’ I ask that person, ‘Why can’t it be helped?’ These phrases are just a way to distract oneself.”

This last comment hints at the tension hospice workers must navigate between taking the expression “it can’t be helped” at face value, or as indicative of the patient’s reluctance to confront some inner form of spiritual pain. In general, most patients are reluctant to discuss

³⁷ Hoshino Tomihiro 星野富弘 (1946-) is a well-known Japanese Christian artist and poet. A former gymnastics teacher, he was paralyzed from the neck down after an accident at the age of twenty-four. He then began painting and writing poems by holding a brush in his mouth and is known for the inspirational quality of his works that celebrate the beauty of nature and the human spirit.

spiritual, let alone religious, questions they might have. For example, in one 2003 study that examined eleven hospice patients for evidence of spiritual distress, none of the interview data included statements related to the category of “transcendence.”³⁸ Similar results were also found in a 2006 survey on what constitutes a good death. Researchers found that of thirteen hospice patients surveyed, only two responded that having faith was important for a good death.³⁹ In my interviews, patients also told me that it was not worth losing sleep over questions about the afterlife, which were questions that “had no clear answer.”

At the same time, hospice workers, and especially chaplains, noted that there were a variety of reasons that could explain the ostensible lack of existential or religious questions from patients. This ranged from reluctance on the part of elderly patients to discuss their personal issues with an outsider to a subconscious repression of spiritual pain. One chaplain also suggested to me that part of the reason that patients are reluctant to talk about spiritual pain is because they feel that posing difficult questions that have no easy answers would *make them a burden* on those who are listening.

As I suggested at the outset of this chapter, this apparent contradiction between the low number of Japanese hospice patients who openly raise questions about the meaning of their life and suffering, the afterlife, or other similar topics traditionally regarded as expressions of spiritual pain, and the conviction of many hospice workers and nearly all chaplains that most patients are in need of spiritual care, can be interpreted in two ways. On one hand, a hermeneutics of suspicion would suggest that the clinical label of “spiritual pain” serves the needs of hospice workers, and chaplains in particular, just as much as the needs of patients. On the other hand, a more charitable interpretation would be that the intuitions of chaplains are

³⁸ Kawa, et al., “Distress of Inpatients,” 488

³⁹ Kei Hirai et al., “Good Death in Japanese Cancer Care,” 144.

sometimes correct—that spiritual pain can be manifested or lie latent in ways that cursory clinical observation will miss. In this section I followed the second interpretation by showing how chaplains suggest that sometimes you need to “dig” for spiritual pain. Since many Japanese traditionally eschew discussing deep personal issues with medical professionals, chaplains argue that spiritual pain needs to be uncovered. This can be a delicate task and chaplains are not naïve about the risk of going about this in an untactful way or of overanalyzing their conversations with patients. At the same time, they also suggest that the concerns patients express about being a burden on their families or the tendency to brush off existential questions *could* still be signs of a “spiritual pain.” This leads us to the next section, where I will discuss a third theme in my interviews, which concerns how the dying experiences of a small minority of patients provide a basis for chaplains to argue that spiritual pain sometimes goes undetected or is even repressed. Furthermore, the nature of these concerns also shows why the chaplain’s religious training is considered integral for addressing the spiritual pain of patients.

“Holding on to Something”

Although the majority of dying patients are not preoccupied with religious belief or a search for something transcendent, a small number do sometimes look beyond their own lives for something to “hold on to” at the end. While few, these examples serve as an important motivator for spiritual caregivers, many who ultimately feel that spiritual care needs to be “vertical,” connecting the patient to something transcendent, as well as “horizontal,” which simply connects patients to those around them.⁴⁰ However, as already discussed, religion generally plays a peripheral role in the day-to-day lives of most Japanese. For most Japanese who are not terribly

⁴⁰ Kashiwagi, “Yamu hito no tamashii,” 42.

concerned with abstract issues of religious meaning and transcendence but find meaning in everyday human relations, it follows that religion plays a very minor role at the end of life as well.

Hara-san, for example, recognized the potential benefit of having something to “hold on to,” but he characterized religion as something for persons with a “weak *kokoro*” and was instead focused on fulfilling his familial obligations:

B. Some patients go through many difficulties when they become ill. For example, their body is in pain, their movements become heavy, and there are many emotional trials. At such times, some turn to religion, or seek to rely on some sort of words or thought...

H. I understand.

B. Yes, they seek something to hold on to. How about you? Do you have something?

H. Not at all. You see certain people—if I say their *kokoro* is weak, maybe this is not the right word— want to hold onto something. I think that humans are weak animals. And those with weak dispositions, they want to hold onto something (*nani ka ni sugaru*). So for example, if it was Christianity, I think some people follow God’s teachings and keep peace in their *kokoro*. And you see, in Japan, there were many wars that during the Warring States Period, and, well, as you know, as these went on, the people who experienced those tough times became convinced that there would be no happiness in this life. So, they prayed for happiness in the next life and put their whole trust in Amida Buddha and others. By doing this, their *kokoro* was saved. When there is something to hold on to, I think people are saved through the *kokoro*. But I’ve never had any feeling like this. More than that, I was [determined] to fulfill my duties somehow or another! (laughs) This was more important!

The views expressed by Hara-san were similar to those expressed by Higashimoto-san, another patient who identified himself as non-religious. In his mid-fifties with stomach cancer, he was mostly relieved to have his pain under control in the hospice after he developed bedsores during a stay at a different hospital. Like Hara-san, Hashimoto-san also described how he felt responsible for taking care of his affairs and the relief he felt as he finally began to tie up loose ends. When I asked if he found any support in religion he answered as follows.

H. Not particularly. However, when you reach this point, I think you begin wanting to hold onto something (*sugaritai mono ga dete kuru* 縋りたいものが出て来る). I’m in this [relatively good] condition, but there may come a time when I will express this.

Perhaps you are reminded of these things [turning to religion] depending on your condition. Well... you can see the talismans over there (gestures to the wall). These are from people who are being sensitive to my condition (*ki o tsukawasete itadaite iru* 気をかわせて頂いている). If I had to say something, I might say this is religious... the way everyone is being sensitive to my condition.

B. You don't have any particular religion?

H. No, I think I'm a typical [non religious] Japanese. Well, I like to think that I understand different opinions better than the average Japanese, and I'm familiar with [the religious affiliation of] our household.⁴¹

As Higashimoto-san explained, it was certainly possible that he might find himself supported by religion, or be reminded of it, when his illness took a bad turn; but in his relatively painless state, he did not consider it of great importance. Even the talismans hanging on the wall that he had received from various friends were explained as simply cultural expressions of concern. He was aware of his household's religious affiliation, but nothing more. He felt good. Unbeknownst to either of us at the time, he would suddenly pass away the next day.

In terms of religious identity, we could say that both Hara-san and Higashimoto-san displayed what we might call "cultural secularism," a form of Japanese religious subjectivity in which "religious and spiritual beliefs and practices are seen as *part of and directed toward* social life" and where religious participation and practice is not based on a distinct religious identity but "is subsumed within broader public morality."⁴² For instance, Hara-san had made

⁴¹ Many non-religious Japanese are often only vaguely aware of what branch of Buddhism their family is affiliated with. By affiliation, this typically only means the temple where their family is buried.

⁴² Gagne, "*Private Religion*," abstract. This is also evocative of "areligious secularism," a term that W. Clark Gilpin employs to describe individuals who tell "secular stories of their lives that incorporate elements derived religious of traditions into narratives that neither favor nor disfavor a religious reading of the self." Gilpin, "Secularism: Religious, Irreligious, and Areligious," *The Religion and Culture Web Form* (March 2007), 10, accessed March 8, 2018, <https://divinity.uchicago.edu/sites/default/files/imce/pdfs/webforum/032007/secularism.pdf>. Wendy Cadge also applies this concept to describe chaplaincy programs in the United States as spaces of "spiritual secularism," where there is a "broad approach to meaning-making than something explicitly connected to religious traditions." Cadge, *Paging God*, 199-200.

arrangements to be buried at an eternal memorial grave where he could be assured of perpetual memorialization without imposing a burden on his single daughter. Likewise, the healing talismans that Higashimoto-san had received from friends were objects with a religious valence, but he saw them rather as symbols of friendly concern for his condition.

For a few patients I met, however, religion did provide something they could more explicitly “hold on to” as they faced the end of life. Yokoyama-san, for example, was a patient in her late fifties who had been fighting cancer for more than a decade. Multiple anti-cancer treatments had taken their toll on her. Upon entering her room, I noticed her head was covered with a head wrap, and her skin tone had darkened considerably. She was quite gaunt and spoke in a raspy voice due to being intubated. She declined to be audio-recorded, and I gathered that she was self-conscious about her voice. We talked for a little bit about her journey to the hospice. She repeated what almost all the patients said about how she did not want to be a burden on her family or cause worry for her neighbors. Her family meant a lot to her.

When I asked Yokoyama-san if she ever drew support from religion, she reached for a notebook by her bed and showed me the first page. Near the top she had written in large characters: *nichi nichi kore kōnichi* 日日是好日, a saying by the Chinese Zen master Yunmen 雲門 (864-949), meaning, “Every day is a good day [from an enlightened perspective].” She explained: “I look at these words in my notebook and say to myself, ‘Today is good. Tomorrow is good. Be grateful for the now.’” She also explained that she considered Fudō Myōō 不動明王 (Skt. Ācālā) to be her guardian deity (*mamori kami* 守り神). She admitted that while others typically look to Amida Buddha or other divine personages for protection, she personally relies on Fudō Myōō. She explained that this began about a decade prior when she was going through a

particularly hard time and began reciting some mantras for encouragement. “I like to chant these when I enter the MRI machine. Going into the MRI is like going into your grave. The old ones anyway were dark inside, although some of the new ones have lights.” In this way, Yokoyama-san indicated that she drew some support from religion as she dealt with the daily challenges she faced in her battle with cancer. These included contemplating Zen sayings and reciting mantras associated with her guardian deity when entering the MRI machine.

An even more striking example of a patient who began to “hold onto” religion at the end of life was a patient called Ogawa-san. Ogawa-san was in her early seventies and was very chirpy as I came into her room. I quickly found out why—she was getting baptized that afternoon. She showed me the small cross necklace on her neck that she had purchased the day before in honor of this occasion. In order to buy the necklace, she had received special permission from her doctor to take a trip to a department store. As we began the interview, she began talking in an excited manner about her decision to get baptized. She explained that before entering the hospice, she was a typical Japanese with no strong religious affiliation.

(O=Ogawa, B=Benedict)

O. I was okay with god(s) (*kami-sama* 神様), I was okay with Buddha (*hotoke-sama* 仏様), and I was okay with Christ (*kirisuto-sama* キリスト様). It really depended on the occasion. When I got sick and met the chaplain, I decided to choose just one. That is all there is to it.

B. Were you not particularly religious before?

O. I had nothing. I was just playing around. I would say things like “if God existed, I should have met him by now,” or “I’ve never seen him.”

B. But you didn’t have any aversion to Buddhism or Christianity in the past?

O. After all, when you die, you are Buddhist, right? During New Years, you go to a Shinto shrine, to the gods, right? And when you get married, a [Christian] chapel is fashionable and convenient, right?⁴³

B. You are very Japanese...

⁴³ Christian chapel weddings are very popular in Japan and account for approximately 60-70 percent of wedding ceremonies in the Tokyo area. LeFebvre, “Christian Wedding Ceremonies,” 192.

O. Aren't I! Those who don't hold any faith might actually have the most peace. They don't have disputes like religious wars.

B. Did you decide to become a Christian after you got sick?

O. My son works here. He helped me get to know the doctors and chaplains; I tend to fall into these things.

B. What made you decide to get baptized? Was it through talking with the chaplains? Or was it your own request?

O. They [the chaplains?] listen to me, and everyone is so kind. You know that Buddhism has the six realms [in the afterlife], and the hells and hungry ghosts are a little frightening. I wasn't always a good person (laughs). I've been cruel to others and rebellious in my life. I'm frightened of going to these places. So I decided to go to the place of Jesus. That is all there is to it. They say he accepts everyone. Isn't that nice... I can go without any cares.

B. Did you have anxiety (*fuan*) before this?

O. No, I didn't. I never really got depressed. It was more like "Oh, well" [in regard to my illness] (*na'chatta mitaina* なっちゃった見たいな).

B. But you were anxious about where you would go after you died?

O. Yes. After all, some Buddhist temples have paintings on the ceilings. Very frightening pictures like the hungry ghost realm. Those are unpleasant, don't you think? In the end, I want to go somewhere without them. I'm going to a place that welcomes everyone.

We talked a little bit about her family. She had encouraged her son to also become a Christian also, but he politely declined. He told her he wasn't that type.

B. What do you talk about with the chaplain?

O. We talk about Christianity, like why he [Jesus] was put on the cross. I've only seen the film *Ben-Hur*. That is about all I know. But I'm glad I saw that. The parts where he is carrying the cross and talking on the hill made a deep impression on me.

As Ogawa-san pointed out, before entering the hospice she was a "typical Japanese" who occasionally engaged in various forms of Buddhist, Shinto, and even Christian religious practices and ceremonies but without any strong sense of religious identity. However, as she reached the end of life, she became concerned over whether she would end up in one of the hell realms described in Buddhism. The Buddhist paintings she had seen had made a strong impression on her. During a subsequent visit, she handed me two and a half carefully handwritten pages that

described in detail the cycle of samsara (*rinne tenshō* 輪廻転生) and the six paths (*rokudō* 六道) of rebirth. At the end of her notes she wrote the following.

The world is eternally non-existent (*mu* 無) beyond death. There is no conception of time. Time is simply a convention for those who are living. The world is as before birth. Because the brain=soul (*tamashii*) will die, it is a non-existent world. Instead of denying death, one should be thankful for the miracle of living in this world for seventy-two years.

Although most of her notes seemed to have been culled from the Internet or some other source, it seemed that the final few lines (which included her own age) represented her own thoughts. It was also slightly perplexing, since the emphasis on “non-existence” (*mu*) stood in contrast with her stated desire to “go to the place of Jesus.”

Ogawa-san was a classic example of a hospice patient desiring to “hold on to something” at the end of life. For Ogawa-san, the unpleasant thoughts of ending up in a Buddhist hell followed by an encounter with a Christian chaplain helped convince her to “choose just one [religion]” and become a Christian. Her knowledge of Christianity was limited to the scene of Christ carrying the cross in the 1959 classic film *Ben-Hur*. But despite lacking access to knowledge about Christianity, she was committed to being baptized and even tried to urge her son to do so as well.

Mizuno-san was another patient who drew support from religious belief—in his case Catholicism. He was in his mid-forties with esophageal cancer. I met him at a Catholic hospice where I spoke with him over two weeks on a near-daily basis. Unlike Ogawa-san, his faith predated his entrance to the hospice. However, his interest in questions about religious faith seemed have intensified after entering the hospice ward. Whenever the hospice chaplain visited him, he plied her with questions. “Should a Christian attend mass even if he dislikes the priest?” This was an issue he was debating with an online friend (In his view, one should, but only if he

could attend without any malice in his heart). On another occasion, he asked the chaplain about what his heavenly body might look like and if the experience would be like a caterpillar turning into a butterfly. In yet another conversation, he lighted on the topic of prayer. He explained to me that in his view Catholics seemed to use silence in prayer much more effectively than Protestants, who mostly want to talk. He explained to me, “It’s good to talk, but the primary purpose of prayer is to listen.”

Mizuno-san also had a bit of a chip on his shoulder and liked to criticize how Japanese society only valued those with successful careers. In his youth, he had wanted to be an astronaut, and had studied physics at a well-known public university. His future career looked bright until he was diagnosed with mild schizophrenia. When he became unable to hold down a job, he began living on social welfare. While receiving psychiatric treatment, Mizuno-san was told by the doctor that he “had a weak ego.” Mizuno-san explained to the chaplain that he now viewed this as a blessing. “Perhaps if my sickness led me to develop a weak ego, it would be a disservice if I were healed!”

Mizuno-san’s efforts to see the silver lining in his struggle with mental illness also extended to his views on death. When he was first informed of his cancer, he said that he was not all that surprised. He even told his parents that he was looking forward to meeting God. Naturally, his parents were upset when they heard this and asked him, who was more important, God or his parents? He told them, “God.” “Even if I could trade places with a healthy person, I wouldn’t.” Even getting married and having a career no longer appealed to him. “I am happy with the now,” he explained. However, there had been just one time when he felt overwhelmed with a fear of death. It happened when he realized that, after he died, he would no longer be able to correct anything said about him. He feared that, as he would only exist in the memory of those

who knew him, it was likely that others might misrepresent him. This thought scared him for a while, but, “I got over it,” he said.

For Mizuno-san, his faith helped him deal with the disappointment of dying so early in life. Death was his chance to “meet God.” His positive outlook was all the more remarkable since his sentences were often punctuated by severe coughing fits. On most nights, this also prevented him from getting sleep. Despite being in constant pain and having missed his chance to lead a normal life, he insisted that he was “happy with the now.” He refused to say that if he could miraculously exchange his body with a healthier one, he would do it. His faith also played a role in how he made sense of his struggle with schizophrenia earlier in life. As he pointed out, his weak ego could be seen as a blessing that drew him closer to God. At the same time, he seemed very sensitive about what others thought of him. For example, one of his primary fears in facing death was not being able to correct others’ misconceptions about him after he was gone.

During his stay in the hospice, the question of whether Mizuno-san was repressing a real fear of death became a topic of discussion amongst hospice staff. Shortly after I was introduced to Mizuno-san, his doctor came by to speak with the chaplain. The chaplain felt that Mizuno-san seemed to be fairly accepting of his death, but the doctor thought differently. In the doctor’s view, whenever he explained to Mizuno-san how his condition was changing, he seemed to grow anxious. The chaplain (who was also a former nurse) encouraged the doctor to ask Mizuno-san directly about this and see what kind of answer he received. After the doctor left, the chaplain explained to me that since most normal people are afraid of death, one could assume that Mizuno-san was, too. However, “There might be one black cow in the herd, and so you have to be aware of that and respect the uniqueness of every patient.”

Patients like Ogawa-san, who undergo a deathbed baptism, or like Mizuno-san, who actively draw on a specific religious tradition for support, are few. Nonetheless, the belief that some patients may find relief by holding on to something at the end is one of the key reasons proponents of spiritual care insist that a religiously trained chaplain should be part of the hospice team. A veteran Catholic chaplain explained it this way:

I think spiritual care can be divided into two levels. One level is shallower, and the other is deeper. The shallow level is spiritual care that all the staff can do. The deeper level addresses questions that only the chaplain is equipped to deal with. For example, when a patient feels “isolated,” there are two levels. Sometimes it just means they are lonely and need someone to sit with them. This is the shallow kind of spiritual care that anybody can provide. Other times, patients feel lonely even when people are with them. This is the loneliness of having to face death alone. This requires the reassurance of a God who can accompany you in life and beyond death. Or maybe a patient might ask: “Why did I get cancer?” Sometimes they just want someone to empathize with them. Other times, they may want to know what God desires them to do in this situation; helping them to address this is a deeper spiritual care.⁴⁴

The chaplain added that although the majority of patients (she estimated eighty percent) are only seeking the shallower form of spiritual care, she felt that her training as a chaplain required her to make herself available to the remaining patients who were looking for something deeper. Such patients represent opportunities for chaplains to draw on their own religious training and identity in providing care.

As these comments suggest, patients who seek to “hold onto something” are a key justification for the work of chaplains in the hospice. While such cases may be few and far between, when a hospice patient expresses an interest in something that transcends their circumstances in the face of death, the presence of a religious professional trained to speak on such matters can be a welcome presence, to both the patient and other hospice staff who may feel unprepared to deal with such patients. These patients not only serve to legitimize hospital

⁴⁴ Personal Interview, March 25, 2015.

chaplaincy as a profession but also function as personal motivators for chaplains. During my interviews I often asked chaplains to describe a memorable past patient. Almost without fail, the patients they told me about had found something to seize hold of that allowed them to transcend death in some way. Books on spiritual care published by chaplains are also full of such examples and these case studies are frequently presented at conferences and in public lectures. Chaplains refer again and again to such cases of patients who do in fact express a wish to have—or gratitude for having—“something to hold on to” at the end. For chaplains and other hospice workers engaged in spiritual care, the presence of such patients, few though they may be, serves to reinforce their claims that a far greater number of terminal patients may either be repressing or otherwise lack the courage to bring spiritual anxieties or existential concerns into the open.

Conclusion

This chapter has sought to question the category of “spiritual pain” by pointing out the tension between the seeming lack of spiritual anxiety voiced by dying patients and the insistence by chaplains and other hospice staff that all patients experience it to some degree. To an extent, the apparent contradiction can be explained by over-earnestness on the part of hospice workers who are invested in the concept of spiritual pain. However, a more charitable interpretation also shows how the anxieties of Japanese hospice patients are sometimes manifested in subtle or deeper ways that elide clinical diagnosis. For example, one Buddhist chaplain was very self-conscious of how his work was often portrayed from a medical perspective that failed to account for, and fell far short of the actual richness of the patient’s dying experience:

Whether it be spirituality, spiritual care, or spiritual pain, I feel like there is an objectification (*taishōka* 対象化) that is occurring and that this approach is emblematic of one-way thinking...At the point when it [spirituality, etc.] becomes something

controlling, or something to be controlled, rather than something that emerges in a relationship, this approach itself becomes an obstacle to deep understanding. When you say, “It should be this,” at the point where you say “this,” intentionality comes into play and things become arbitrary. When this happens, this aspect of control and something to be controlled surfaces, and you lose what was originally a very rich thing. It becomes too narrow or even trivialized. I think these [concepts] refer to something that is essentially very rich, thick, and deep. While these concepts provide us an opportunity to help us touch on these things, I think there is a danger to saying, “It’s this!” since this will overlook all kinds of things. So my own image of spirituality is very rich, and at the point in where you turn it into “something,” I feel like it is becoming trivialized.⁴⁵

This chaplain felt that as helpful as the concept of “spiritual pain” was in legitimizing his profession, there was also a danger of applying this concept too liberally, and trivializing the deeper anxieties that patients might be facing at the end of life.

This mismatch between the label of “spiritual pain” and the lack of reported patient spiritual anxiety is particularly significant in Japan for several reasons. First, most Japanese patients have no idea what the term “spiritual pain” really means, or why the chaplain is there. Thus from the patient’s perspective, “spiritual pain” is an empty or at best an amorphous concept. Second, most Japanese hospice patients describe themselves as not religious and only rarely raise questions about a search for meaning or belief in something transcendent at the end of life. This calls into question of traditional definitions of “spiritual pain” that are focused on a “search for meaning.” Although some patients may occasionally express anxiety or concerns about guilt, meaning, the afterlife, or their relationship to some transcendent power, the majority either appear unconcerned, or, at the very least, tend to ignore these questions; instead, they voice their concerns about social relationships, being a burden on others, and their unfinished duties toward family and friends. Third, the practice of sharing personal dilemmas with chaplains—let alone deep existential questions—remains culturally incongruous for many, particularly elderly, Japanese patients. As a result, when a patient is believed to have “spiritual pain,” it can be

⁴⁵ Personal interview, May 21, 2015.

difficult to address it directly. Instead, spiritual caregivers circle the patient and focus on allowing that person to spend his or her last days in a way that they believe will allow the patient to “be himself” or “be herself” and thereby find meaning in the midst of death. In this way, we see how the concept of spiritual pain does not stem from the patient’s own experience but is primarily produced and elucidated *through the work of caring* for the patient.

None of this is to deny the utility of spiritual pain as a useful concept in clinical settings. The challenges that Japanese chaplains face in justifying their work or even making it comprehensible to their fellow medical workers who are steeped in biomedical frames of reference, make the concept of “spiritual pain” critical for practicing spiritual care at the end of life. Moreover, those few patients who do seek out something “to hold onto” give chaplains and other proponents of spiritual care a reason to believe that at least some patients do in fact have deep existential needs that clinical psychologists cannot fully address. In the meantime, chaplains and other staff focus on meeting the more prosaic needs of patients. In addition to sitting and listening to patients, the work of chaplains also consists of “supportive care,” which includes interacting with patients through tea gatherings, gardening, walks, concerts, birthday parties, seasonal festivities, and impromptu movie screenings, all conducted with the goal of helping patients to “be themselves.” If Nakano Kōji, who was introduced at the very beginning of this chapter, had entered hospice care, no doubt arrangements would have quickly been made to ensure that he could walk his dogs. This speaks to a more embodied understanding of spiritual pain and spiritual care that does not seek to distinguish between the physical, social, psychological, and spiritual dimensions of a patient’s “total pain.” Rather, the search for “spiritual pain” ends when we see that the ultimate concerns of hospice patients are inextricably

embedded in a dynamic bricolage of physical practices, social relationships, psychological pressures—and in some cases, religious beliefs—that are a part of what we normally call “life.”

Conclusion

I had just finished my last nurse interview for the day. As I put away my notes in a clear file and returned the recording device to my bag, the nurse lingered in the room. I sensed she wanted to ask me something. Sure enough, she blurted out, "Have you ever met someone who committed suicide?" I was caught off guard. "You mean like a patient?" "Yes, in your past dealings with patients, have you ever met someone like this?" I racked my brain. "Umm... well let me see. I've met many patients who told me they wanted to hurry up and die. But I don't think I've ever met a patient who actually did it. Some patients have told me that in the past they tried to commit suicide. Why do you ask? Have you?" It was only when I looked up at her that I realized she was staring at me intently. I didn't notice it right away, but her eyes were beginning to water behind her glasses. "Yes... before I came here." I still didn't notice. "Was this something that motivated you to work in the hospice?" "Yes..." She paused. It now finally dawned on my dull brain that she was on the verge of crying. "Kind of." I waited for her to go on but she smiled with embarrassment as she removed her glasses and wiped her eyes with her finger. There was a long pause, and I tried to give her some space. I resumed packing up my things and tried to think of something to say. She looked out the window at the gray clouds and changed the subject. "Did you come in the rain?" "Yes, I did." "Do you live far away?" "Actually, I live on this train line. In fact, my wife grew up in this area." "Oh, wow. That's nice." My bag was packed and I wanted to return to her question but I was afraid to look like I was prying. I reached down and picked up the paper cup I had left on the table. It was still full of hot green tea. I tried to stall. "Well, I don't want to waste this." I drank a little more than half of it, but I was still at a loss for the right words. Putting the cup down, I said, "Ahh, That's nice." She

laughed, and I could see that she was still wiping her eyes and trying to compose herself.

After a brief pause, I thanked her again and left the room.

As soon as I left the room, I knew I had blundered spectacularly. How could I have been so stupid as not to realize that she was trying to share something very close to her heart? How could I have been so inept in my response? Something in my interview had prompted her to recall a formative past experience with a patient. But the moment to let her tell this story was now gone. As I walked to the train station the rain sprinkled down on me. There was a gnawing sensation in my stomach. I knew that I would be haunted for a long time by the sight of her tear brimming eyes that were filled with a deep pain.

This was not the first time during my fieldwork that a nurse or doctor began to cry during an interview. At the end of an interview, I often asked doctors, nurses, and chaplains if they would be willing to share a story about a memorable patient. I was aware that when I asked this question I was treading on sacred ground. Thankfully, one nurse told me after the interview that she felt “relieved” and “healed” by sharing memories of her patients. But I knew that I was only scratching the surface. Just as patients could never share everything they felt with hospice workers, hospice workers were constrained in speaking with me. The connections they felt with patients ran deep.

I begin the conclusion to my dissertation on this note to emphasize how many stories I have left behind. As with any ethnographic effort, I am under no illusion that I have chronicled anything close to a complete picture of spiritual care in Japan. This is particularly the case in

considering the final and ultimate concerns of patients. There is a certain futility in putting the actual patient's experience of death and dying into words.¹

However, while I may not have been able to do justice to every hospice patient I interviewed for this dissertation, I do believe my fieldwork has yielded some helpful insights about spiritual care in hospice settings that speak to the religious dimensions of care for the dying in Japan and to Japanese religions more broadly. In Chapter Two, I began by addressing the formative historical, cultural, institutional, and discursive contexts of religious engagement in medicine during the long twentieth century that culminated in the hospice movement. In Chapter Three, I addressed the semantic ambiguities of the term "spirituality" that are employed by hospice workers in sanctioning or prohibiting the acceptable parameters of religious care for dying patients. In Chapter Four, I drew on my ethnographic fieldwork to show some of the unexpected ways that spiritual care is offered in practice. And in Chapter Five, I used interviews with hospice patients themselves to demonstrate the primary concerns that they have in facing death and the difficulties that hospice workers face in determining what constitutes "spiritual pain" at the end of life. Here I will review some of the broader themes that span the previous chapters.

Spiritual Care as a Global and Trans-Denominational Conversation

One key theme of this dissertation is that spiritual care in Japan is part of a global conversation. For instance, in Chapter Two I showed how Western medical missionaries helped establish Christian hospitals that later became some of the formative sites for the development of

¹ Suhita Chopra Chatterjee, "Understanding the Experiential World of the Dying: Limits to Sociological Research," *Omega* 41, no. 2 (2004): 91-98.

models of spiritual care. Their efforts also helped spur Buddhists to develop their own vision for hospice care through the Vihāra movement. In Chapter Three, I also showed how the application of spirituality as a clinical term in Japan has been accomplished through the circulation and appropriation of international discourses on spiritual care initiated by figures like Cicely Saunders or organizations like the WHO. Hospice pioneers and chaplains in Japan traveled widely to England, the United States, and elsewhere to observe and be trained in the practice of spiritual care. More recently, these conversations have spread to other parts of Asia, as Japanese hospice workers and chaplains interact with their colleagues in neighboring countries such as Taiwan and Korea. Some of the venues for these conversations include annual conferences organized by the Asia-Pacific Hospice Palliative Care Network as well as informal visits between hospitals. Yodogawa Christian Hospital, one of the earliest sites of Japanese hospice care, has regular exchanges with Christian “sister hospitals” in Korea and Taiwan. Japanese Buddhist groups have also traveled to Taiwan where Buddhists are active in providing spiritual care to hospice patients, including at the National Taiwan University Hospital.² In 2016, the Rinbutsuken Institute for Engaged Buddhism in Tokyo even featured a special tour of Buddhist chaplaincy training programs and institutions in the United States that included visits to Naropa University in Colorado and the Zen Hospice Project in San Francisco.

These global conversations between spiritual care practitioners help remind us of the important influence of globalization on Japanese religion.³ The introduction of spiritual care to

² Takashi Nishide, “Taiwan leads Asia in spiritual care to alleviate fear of death,” *The Japan Times Online*, May 21, 2014, accessed February 1, 2018, <https://www.japantimes.co.jp/news/2014/05/21/national/taiwan-leads-asia-spiritual-care-alleviate-fear-death/>.

³ Galen Amstutz and Ugo Dessì eds., “New Research on Japanese Religions under Globalization,” Special issue, *Journal of Religion in Japan* 3 (2014); Ugo Dessì, *Japanese Religions and Globalization*

Japan is not only about the circulation of foreign ideas and practices but is also a process in which the global and the local interact to produce something new. Cultural and religious borders are places of great resistance and production. Therefore, rather than viewing spiritual care as something that was simply imported to Japan from British hospice care or handed down to hospice workers by the WHO's definition of palliative care, we can see the “glocalization” of spiritual care. This study has shown how spiritual care is simultaneously embedded in global discourses on the definition and practice of spiritual care and assuming new forms in local spaces.⁴ Local context is essential to avoid portraying spiritual care as simply a “foreign” import to Japan. Instead, as we saw in Chapter Three, hospice workers have been active in defining and interpreting theoretical models of spiritual care in ways that reflect the particularities of the Japanese social and religious context. That context includes ignorance on the part of patients about what “spiritual care” even means; the large numbers of Japanese patients who describe themselves as “not religious”; and a society-wide suspicion towards the work of religious professionals in general, let alone in delicate spaces like hospices. As a result, even though hospice workers are conscious of some of the Western theoretical models of spiritual care found in hospice care literature that emphasize the need to provide existential counsel to and help

(London and New York: Routledge, 2013); Ugo Dessì, *The Global Repositioning of Japanese Religions: An Integrated Approach* (London and New York: Routledge, 2016).

⁴ The concept of “glocalization” comes from Roland Robertson who uses it to refer to the simultaneity of universalizing and particularizing tendencies. Robertson borrowed this term from Japanese economists who used this word in several *Harvard Business Review* articles during the 1980s. Robertson traces the origins of this word to the Japanese term *dochakuka* 同着化 which refers to “indigenization.” But as Uesugi Tomiyuki points out, the term used by Japanese economists in marketing strategies during the 1980s was in fact *genchika* 現地化 or “localization.” However, Robertson’s term has now been rendered back into Japanese as *gurōkarizēshon* グローカリゼーション. Roland Robertson, “Glocalization: Time-Space and Homogeneity-Heterogeneity,” in *Global Modernities*, Mike Featherstone, Scott Lash, and Roland Robertson eds. (London: Sage Publications, 1995), 28-32; Uesugi Tomiyuki, “‘Gurōkaru kenkyū’ no kōchiku ni mukete: Kyōshin suru gurōkarizēshon no sataishōka,” *Nihon jyōmin bunka kiyō* 27 (2009): 43-75, 191.

patients find “meaning” at the end of life, in practice, their work is more diffuse and “supportive,” as I showed in Chapter Four. That is to say, they often see spiritual care as occurring in the margins of other types of care through very prosaic interactions or activities that help patients feel valued, without explicitly addressing existential concerns.

By framing these exchanges and negotiations between Western and Japanese discourses on spiritual care as a conversation, I have also tried to avoid projecting a narrative that sees the development of spiritual care in Japan as a Western or Christian imposition on “Japanese” forms of end of life care. Instead, I have tried to show how spiritual care in Japan is part of a series of cross-cultural interactions. As Nicholas Standaert has observed in his analysis of the cultural transmission of Christianity to China, models predicated on the success or failure of a cultural transmission suffer from two pitfalls: impact-response and essentialism. By impact-response Standaert refers to the assumption that the incoming transmission had an active role that “impacted” the passive entity. By essentialism Standaert refers to the propensity to mark a cultural entity as having a quasi-invariable essence. On the other hand, the more useful paradigm of interactions “does not reject the concepts of impact and response, action and reaction, or means and effect, but considers them to be more descriptive and less evaluative.”⁵ In the same way, the development of spiritual care in Japan can be seen as a series of ongoing interactions between Japan and other cultural sites where spiritual care is practiced, and also as something that is grounded in the local historical, cultural, and institutional contexts of Japanese religious engagement in medicine.

⁵ Nicolas Standaert, “Christianity in Late Ming and Early Qing China as a Case of Cultural Transmission,” in *China and Christianity: Burdened Past, Hopeful Future*, Stephen Uhalley, Jr. and Xiaoxin Wu eds. (Armonk, NY: M.E. Sharpe, 2001), 88-89.

In addition to showing how cross-cultural conversations on spiritual care between Japan and other places are taking place in hospices, spiritual care training programs, conferences, and publications around the globe, this dissertation has also drawn attention to the importance of studying the role of Buddhist-Christian interactions in shaping the Japanese spiritual care movement as a whole.⁶ As I discussed in Chapter Two, the arrival of Christian medical missionaries in the late nineteenth century sparked something of a rivalry between Buddhist and Christian groups that led to the founding of numerous religious hospitals and organizations providing medical care. By the end of the twentieth century, and especially in the wake of the Aum sarin gas incident, however, Buddhist and Christian groups were largely cooperating together with the common goal of establishing a model for religious involvement in care for the dying. This was actualized through the founding of Christian and Buddhist hospices where the practice of spiritual care helped religious groups show the “healthy” role religion could play in modern medical spaces, and especially in care for dying. Religious involvement in hospice care also led to the establishment of several interfaith spiritual care training programs. In examining these ecumenical interactions, we find that clinical models of spiritual care do not necessarily break down along religious lines. As I show in Chapter Three, some Buddhists and Christians agree, and others disagree, on the extent to which religion should play a role in spiritual care or on how to define spirituality. This shows that contemporary spiritual care is not framed by the explicitly soteriological concerns that Buddhists and Christians have traditionally subscribed to in their care for the dying. For example, while Buddhists trace their hospice care expertise to the

⁶ For more on modern interreligious dialogue between Buddhism and Christianity in Japan, see Notto R. Thelle, *Buddhism and Christianity in Japan: From Conflict to Dialogue, 1854-1899* (Honolulu: University of Hawaii Press, 1987). See also Minoru Kiyota ed., *Japanese Buddhism: Tradition, New Religions and Interaction with Christianity* (Tokyo and Los Angeles: Buddhist Books International, 1987), 135-192.

pre-modern practice of *rinjū gyōgi* rites in which Buddhist adepts helped the dying achieve right-mindfulness at death, the connections between these two forms of terminal care are mostly rhetorical gestures. In practice, contemporary spiritual care is more often framed in psychotherapeutic rather than soteriological terms.

Critiquing “Spirituality”

This dissertation has also sought to cast a critical eye on the concept of “spirituality” as it is employed in academic and clinical scholarship on hospice care. Namely, I have tried to show how the term “spirituality” serves to negotiate the flexible boundaries between religion and the secular as a means to legitimize and valorize the role religious workers play in Japanese hospice care. For example, in Chapter Three, I traced the genealogy of scholarly and clinical discourses on spirituality in Japan that shows how spirituality and care for spiritual pain are defined in such ways that different stakeholders can sanction or prohibit the acceptable parameters of religious care for patients. In other words, the term “spiritual” is best understood as a label that negotiates the movable boundaries between the religious and the secular. It is a term that allows chaplains to manage the ambivalent nature of their work, working as religious experts who must minister to patients in non-religious ways. I also demonstrated how the semantic ambiguities in the term “spirituality” have served to create a cornucopia of definitions in professional and academic literature that seek to establish exactly what the word “spiritual” means in the Japanese clinical context. The net effect of this discourse has been a reification of the concept of spirituality that distinguishes between it, and the physical and psychosocial dimensions of hospice care. At the same time, spirituality is emphasized as a dimension of personhood that all patients have—allowing clinicians to pinpoint the locus for spiritual pain. The turning of spirituality into

a dimension of personhood has the advantage of making chaplains into experts who can treat the pain emanating from a patient's "spirituality." But this also calls into question whether the emphasis on the etiology of spiritual pain, in which pain is attributed to the existential crises that accompany death, also serves to undermine the very original ethos of hospice care: namely, Saunders' original call to simply treat the patient as a "whole person."

By focusing on the ways lines are drawn differently between the "spiritual" and the "religious," this study has also shown some of the ways that more explicitly religious forms of care in hospice settings are marginalized in practice. In Chapter Four, I showed how chaplains only rarely offer patients explicitly religious care but rather spend much of their day providing supportive care. Framing their work as "spiritual" and not religious, allows chaplains to utilize a strategically vague frame that makes their work more palatable to patients, the patient families, and other medical staff members. However, this vague frame also occasionally creates confusion over how the chaplain's work might differ from that of a clinical psychologist. In defense of their work to medical colleagues confused about the chaplain's role, many chaplains frame their contribution as religious experts who have "something unmovable behind them" that patients appreciate, as opposed to clinical psychologists who may not be able to point patients toward anything that might allow them to transcend their situation. In support of their role, chaplains cite cases of patients such as those introduced in Chapter Five, who reported the value of having found something they could "hold on to" as they approach the end of life. Although such patients are few, they are important for chaplains to show that their religious training can be of aid in practicing spiritual care and legitimize their work, even when it is defined as "spiritual" rather than "religious." In this way, we see how the ambiguous term "spiritual" can be used to both prohibit and sanction the role religion plays in spiritual care.

Religion at the Japanese Deathbed

Finally, this dissertation has sought to provide new insights on the role religion plays—and does not play—in the lives of dying Japanese patients. At the beginning, I questioned what role religion might play for hospice patients who claim to be “not religious.” In light of the fact that most Japanese are dedicated as children at a Shinto shrine, married in a Christian chapel, lead a mostly secular life, and will likely have a Buddhist funeral, what role does religion play at the end for Japanese patients? The answer to this question is complex. As I demonstrated in Chapters Four and Five, most hospice patients rarely talk about religion at all. Accordingly, chaplains and other hospice staff often practice a form of spiritual care that eschews explicitly religious support and instead seek to help patients “be themselves” through the continuation of activities and maintenance of relationships that bring them joy. However, this is not to deny that patients who self-identified as “not religious” necessarily failed to appreciate religious care. Many such patients told me about how much they enjoyed listening to the Buddhist or Christian services at the beginning of the day or listening to hymns that reminded them of the Christian schools they had attended in their youth, or of celebrating various Buddhist or Christian holidays. Their comments reinforce the conclusions drawn by Jesse LeFebvre in his study of Christian wedding ceremonies in Japan, where he argues that the self-designation “not religious” in Japan simply means that one is not cognitively committed to the tenets of any particular religion; persons who claim to be “not religious” are often quite happy to participate at an affective level in a range of religious services offered by religious professionals.⁷

⁷ LeFebvre, “Christian Wedding Ceremonies.”

Although few, there are also some hospice patients who do turn to religious beliefs or practices to transcend or overcome their anxieties in the face of death. As noted above, these patients provide a particularly important rationale for legitimizing the work of chaplains, who sometimes struggle to articulate their role on the palliative care team to other skeptical hospice workers. Patients who find comfort through religious support also offer chaplains validation of their suspicion that many patients may have latent or repressed spiritual concerns that require their attention. In most cases, however, patients are far more likely to express anxiety about being a burden on their family and dismiss existential concerns that “cannot be helped.” As such, chaplains spend much of their time in the ward supporting patients in pedestrian—but still meaningful—activities that help the patients “be themselves” and feel valued and appreciated at the end of life.

Final Words

As this dissertation has showed, religion in contemporary Japan is both shaping and being shaped by care for the dying modern medical spaces. Conceptualizations of spiritual care are marked by important tensions between demarcation of the religious and the secular, between discourse and practice, between the needs of patients and the needs of hospice workers, and between the assumed presence of spiritual pain in terminal patients and denials by patients about such concerns. As I experienced, ethnography is a powerful tool that allows us to uncover these tensions. At the same time, there are also limits to illuminating the experiences of dying patients. As Paul Willis suggests, sometimes in ethnography, linguistic communication “flattens rather

than evokes phenomena.”⁸ In my interactions with patients and hospice workers, I too often felt this “flattening” of the patients’ experiences as they entered my field notes. The many tensions and conflicting accounts that I found in the practice of spiritual care and lives of patients begged for new frames to put them in relation with each other and also to account for differences and silences in their stories. In other words, there is still a lot of work to be done, and I see this study as not the end, but, the beginning of such a conversation. Fortunately, as long as everyone has a stake in death, we can expect that the study of how humans face their ends will continue for quite some time. Hopefully, this will lead to better understandings of the role religion plays at the end of life, which will in turn, help future ethnographers bring death to life.

⁸ Paul Willis, *The Ethnographic Imagination* (Cambridge, UK: Blackwell, 2000), 118.

Appendix I

Religious Hospices in Japan

	Hospital Name	Location	Hospice Est.	Hospital Est.	Religion
1	Seirei Mikatahara Hospital	Shizuoka	1981	1930	Protestant
2	Yodogawa Christian Hospital	Osaka	1984	1955	Protestant
3	Salvation Army Kiyose Hospital	Tokyo	1989	1939	Protestant
4	Eikoh Hospital	Fukuoka	1990	1986	Protestant
5	Nagaoka Nishi Hospital	Niigata	1992	1967	Buddhist
6	Kobe Adventist Hospital	Hyogo	1993	1973	SDA
7	Jesus No Mikokoro Hospital	Kumamoto	1994	1895	Catholic
8	Sakuramachi Hospital	Tokyo	1994	1939	Catholic
9	Japan Baptist Hospital	Kyoto	1995	1955	Protestant
10	Mt. Olives Hospital	Okinawa	1995	1958	Protestant
11	Shin-ai Hospital	Tokyo	1996	1909	Protestant
12	Tokyo Adventist Hospital	Tokyo	1996	1929	SDA
13	Himeji St. Mary's Hospital	Hyogo	1996	1950	Catholic
14	St. Mary's Hospital	Fukuoka	1997	1953	Catholic
15	Hikarigaoka Spellman Hospital	Miyagi	1997	1955	Catholic
16	Aiwa Hospital	Nagano	1997	1991	Protestant
17	St. Lukes International Hospital	Tokyo	1998	1902	Episcopal
18	Sanikukai Hospital	Tokyo	1998	1918	Protestant
19	Shinsei Hospital	Nagano	1998	1932	Anglican
20	Kinugasa Hospital	Kanagawa	1998	1947	Protestant
21	St. Francis Hospital	Nagasaki	1998	1949	Catholic

22	Aichi International Hospital	Aichi	1999	1981	Protestant
23	Matsuyama Bethel Hospital	Ehime	2000	1982	Protestant
24	St. Johannes Hospital	Fukuoka	2001	2001	Catholic
25	Koyama Fukusei Hospital	Shizuoka	2002	1889	Catholic
26	Yukawa Ichō Hospital	Osaka	2002	1902	Protestant
27	Salv. Army Booth Memorial Hospital	Tokyo	2003	1916	Protestant
28	Adventist Medical Center	Okinawa	2003	1953	SDA
29	Risho Koseikai Hospital	Tokyo	2004	1952	NRM
30	Gratia Hospital	Osaka	2005	1953	Catholic
31	Mie Seijuji Hospital	Mie	2005	2005	Catholic
32	Vories Memorial Hospital	Shiga	2006	1918	Protestant
33	Seirei Sakura Citizen Hospital	Chiba	2008	2004	Protestant
34	Asoka Vihara Hospital	Kyoto	2008	2008	Buddhist
35	Seirei Hospital	Aichi	2009	1947	Catholic
36	Shalom Hospital	Saitama	2016	1994	Protestant
37	Megumi Hospital	Fukuoka	2017	1999	Buddhist

Appendix II

Spiritual Care Training Programs

Over the last two decades, multiple Japanese spiritual care training programs have emerged that vary in size, curriculum, and mission. Until recently, these programs largely operated independently and set their own requirements for training. However, this also meant that the medical community mostly ignored the certification they provided. Due to this haphazard state of affairs, in 2012, the Japan Society for Spiritual Care (JSSC) set upon creating a national certification program that would establish the minimum criteria for chaplaincy training and set the stage for recognition of spiritual care in Japan as a profession in its own right.¹

Individuals who receive certification from the JSSC are called *Supirichuaru kea shi* スピリチュアルケア師. The suffix “shi” indicates a “professional” and mirrors the suffix used for other types of medical professionals including doctors (*ishi* 医師), nurses (*kangoshi* 看護師), and clinical psychologists (*rinshō shinrishi* 臨床心理師). Currently, three types of certifications are offered by the JSSC at the levels of: certified (*nintei* 認定), specialist (*senmon* 専門), and instructor (*shidō* 指導). According to the JSSC website, by the end of 2017, a total of 220 certified, 64 specialists, and 69 instructors have been granted certification. This certification is also subject to renewal every five years and requires active participation in the annual JSSC conference. The hope of those who support certification for spiritual care training is that the work of chaplains would be publicly recognized and placed on equal footing with other hospice staff who are also certified in their respective areas of expertise.

¹ For further details, see the JSSC Website, <http://www.spiritualcare.jp/>.

Practically speaking, however, early results suggest that there is a long road ahead. For instance, a staff member at one of the training programs mentioned to me that very few graduates of their program have been able to utilize their certification to procure full time work as chaplains. Although some graduates do work part time or on a volunteer basis to provide spiritual care at hospitals, nursing homes, or other institutions, the number of openings for hospital chaplains remain small. Since spiritual care is not billable under Japan's national health insurance system, there is also little financial incentive for institutions to hire chaplains.

Although the JSSC provides this certification, the training itself takes place in various independent training programs that meet the minimum requirements of the JSSC. The first basic level of "certification" requires 48 hours of educational training on Japanese culture, religion, traditions, psychology, and spirituality; 60 hours of group work and clinical supervision; as well as at least 120 hours of clinical practice. The next level of "specialist" certification requires approximately double these hours of training. As of 2017, the JSSC recognizes nine programs that can be used to fulfill these requirements. These include training provided by the Clinical Pastoral Education and Research Center, the Tokyo Mitorinin Project, the Grief Care Research Center, the Japan Spiritual Care Workers Association, the Professional Association for Spiritual Care and Health, the Kōchi Cancer Patient Support Group, Center for Practical Esoteric Buddhism at Koyasan University, the Department of Practical Religious Studies at Tohoku University, and the Graduate School of Practical Shin Buddhist Studies at Ryūkoku University. I have included a short description of five of these programs below.

Clinical Pastoral Education and Research Center (CPERC)

<http://pastoralcare.jp/>

This program was founded by the German missionary Waldemar Kippes (1930—) as one of the earliest spiritual care training programs in Japan. Kippes, as discussed in Chapter Three, was a Catholic priest who first arrived in Japan in 1956, and completed a Ph.D. in counseling psychology from Loyola University Chicago in 1976. Besides teaching at various Catholic universities, he also served as a supervisor at a suicide prevention telephone line in Tokyo. In 1991, he began teaching pastoral care to staff at Himeji St. Mary's Hospital in Hyogo. In 1998, he founded the CPERC and continues to serve as its director. The program offers a both a degree and volunteer course. According to the Center's website, the degree course requires a minimum of thirty days of field work at a hospital, a total of thirty verbatim reports, eight book reports, personal supervision both during and after the course, and a minimum of 120 hours of philosophical-theological studies. Between 1998 and 2012, 1516 people participated in the five-day and three-day training courses that the Center provides and has produced a total of 102 degree graduates.

Professional Association for Spiritual Care and Health (PASCH)

<https://sites.google.com/site/paschspirit/>

This program was founded in 2005 with the aim to provide a program that closely resembled the Clinical Pastoral Education (CPE) courses of instruction in the United States. Accordingly, many of the primary instructors were educated in the United States. For example, one of the early instructors, Kubotera Toshiyuki, received his Master of Divinity degree from Emory University in 1972 and a Master of Theology degree from Columbia Theological

Seminary in 1975. Itō Takaaki, who was also one of the main instructors in the program, received his Master of Divinity degree from Church Divinity School of the Pacific, and also served as a CPE supervisor at Stanford Hospital between 2001-2002. Likewise, Konishi Tatsuya, another instructor in the program, served as an interfaith chaplain for a year in California and obtained a masters degree at Harvard Divinity School before returning to Japan.

The training PASCH offers is called the “Curriculum for Spiritual Care Clinicians” (CSCC), and it was first offered in 2006 for seven participants. By 2017, over 200 participants had taken part in the program. The first part of the program focuses on group work and takes approximately five intensive days to complete. Group work includes sharing about personal backgrounds, goals, presenting verbatim reports (which record conversations with patients) to peers for feedback, and self-assessment. After this initial training is finished, trainees then follow up with their supervisors periodically for feedback on their work at whatever institution they are affiliated with. The program is modeled after the programs that the U.S. based Association for Clinical Pastoral Education (ACPE) provides, but is modified to address Japanese clinical needs and the length of the training is shortened considerably since most current or aspiring chaplains in Japan would not be able to meet the longer training requirements that American chaplains undergo which include 100 hours of classroom training, and 300 hours of clinical training to conclude one Clinical Pastoral Education unit (board certification requires an additional 1200 hours).

Japanese Spiritual Care Worker Association (JSCWA)

<http://jscwa.jp/index.html>

The JSCWA originated from a group called the “Esoteric Buddhist Welfare Research

Association” (*Mikkyo fukushi kenkyū kai* 密教福祉研究会) that was formed in the aftermath of the Hanshin Awaji earthquake in 1995. In 2001, the group then began training “*Kokoro Consultation Workers*” (*Kokoro no sōdan in* 心の相談員) on Mt. Koya. In 2006, the JSCWA was formed with the goal of raising, training, and networking spiritual care workers. They also began offering a two-year training program.

The first year of the program is made up of teaching units on a variety of topics including the relationship between spiritual care and nursing, welfare, mental illness, Shinto, or Buddhist esoteric practices. In the second year, students undergo supervised training in the field. By 2014, over three hundred trainees had participated in the program and it had produced ninety graduates. Past students include doctors, nurses, other types of caregivers as well religious leaders. Although the JSCWA program is based on Mt. Koya, the headquarters of Shingon Buddhism, the program has also included Christian instructors like Kubotera Toshiyuki. However, the majority of classes are currently taught by the Shingon priest Ōshita Daien who helps lead the program. The Buddhist flavor of the program further emerges in its handbook, which in 2014 included the aims of studying Buddhist principles such as: alleviating suffering through “kindness, pity, joy, and impartiality” (*jihi kisha* 慈悲喜捨)²; “all sentient beings possess Buddha nature” (*issai shujyō shitsu u busshō* 一切衆生悉有仏性); “improving oneself and bringing benefit to others” (*jiri rita* 自利利他); and “living beings helping and learning from each other” (*kyōri gunjō* 共利群生).³ It is suggested that these principles form the basis for Buddhist thought on social welfare and that JSCWA’s mission is to use these to support the

² These are also known as “the four immeasurable states of mind” or *Shimuryōshin* 四無量心. Nakamura, *Bukkyōgo daijiten*, 714.

³ JSCWA, “Heisei 26 nendo supirichuaru kea wākā yōsei kōshūkai: Kōza yōkō” (February 1, 2014), 1.

hearts of those in need.⁴

Grief Care Research Center (GCRC)

<https://www.sophia.ac.jp/jpn/otherprograms/griefcare/about.html>

The GCRC was established in 2009, but owes its existence to a tragic railway accident that occurred in 2005 in Hyōgo prefecture when a train derailed on a curve and crashed into a nearby building. The accident, which was due to the train operator's error, injured more than 500 and claimed 106 lives. In response to this accident, the West Japan Railway donated two billion yen (approximately 20 million dollars) in 2009 to set up the nonprofit JR-West Relief Foundation (JR 西日本あんしん社会財団 *JR Nishinihon anshin shakai zaidan*). Since then, this foundation has supported research and activities that promote safety and relief in Japanese society, including the Grief Care Research Center which began in 2009 at St. Thomas University, located near the site of the rail accident. In 2010, the Center was moved to Sophia University in Tokyo.

The GCRC's objectives are to promote research on grief care and train caregivers through educational activities. They offer several training programs including a one year and two year Grief Care Certification course, both of which count for JSSC certification. The course includes the study of grief care, spiritual care, religion, thanatology, as well as a clinical practicum. In terms of student background's, about one-third of the students are nurses, although there are a few Buddhist priests and Christian laity, the majority of the students have "no

⁴ Interestingly, however, the 2017 version of the handbook left most of this wording intact but removed the references to "kindness, pity, joy, and impartiality," and to "Buddha nature." JSCWA, "Heisei 29 nendo supirichuaru kea wākā yōsei kōshūkai: Kōza yōkō" (April 5, 2017), accessed May 6, 2018, http://jscwa.jp/wp-content/uploads/2017/02/scw2017_ver01.pdf.

religion.”⁵ The Center is also notable for being directed by Shimazono Susumu after his retirement from the University of Tokyo in 2013.

Department of Practical Religious Studies at Tohoku University

<http://www2.sal.tohoku.ac.jp/p-religion/2017/cn8/pg27.html>

This program seeks to train chaplains who are called *Rinshō shūkyōshi* (臨床宗教師 lit. clinical religious professionals). Like the Grief Care Center, this training program also grew out of a disaster. In this case, it was the relief efforts that followed the March 2011 earthquake and tsunami that helped cement cooperation between religious groups. Inspired by the activities of religious leaders in helping disaster victims, and especially the work of a “*kokoro* consultation room” that provided *kokoro* care to victims, the Department of Practical Religious Studies was formed at Tohoku University to train and conduct research on *kokoro* care. In 2012, they offered their first training program with twelve participants. The religious backgrounds of participants are primarily Buddhist but participants also include Christians, members of New Religions, Shinto professionals, and on one occasion, a Muslim. By March 2018, the program had produced 146 graduates with basic certification along with 20 supervisors.⁶

Initially, the six-day program was taken three days at a time and included lectures (22 hours), group work (28 hours), and fieldwork (24 hours). Now, the program involves meeting as a group for two or three days on three separate occasions interspersed with two months of fieldwork. The training is provided free of charge with participants covering their own lodging,

⁵ Taniyama, “The Vihara Movement,” 88.

⁶ “Nintei rinshō shūkyōshi ichiran,” Society for Interfaith Chaplaincy in Japan (SICJ) Website, last modified March 3, 2018, accessed May 21, 2018, http://sicj.or.jp/uploads/2017/11/nintei_list-1.pdf; “Rinshō shūkyōshi kenshū shidōsha ichiran,” Society for Interfaith Chaplaincy in Japan (SICJ) Website, last modified March 5, 2018, accessed May 21, 2018, http://sicj.or.jp/uploads/2017/11/sv_list.pdf.

food, and travel expenses. Examples of fieldwork locations include home hospice and hospice wards, a Buddhist café for disaster victims called “Café de Monk,” a Christian center that lets residents bring food to be checked for radioactive contamination, a telephone counseling station, as well as nursing and care homes. Fieldwork also includes a “memorial pilgrimage” (*tsuitō junrei* 追悼巡礼) during which all the participants don their religious garb and walk single file through areas affected by the March 2011 disaster while praying or reciting scripture for the souls that were lost. The sight of various religious professionals marching together through devastated areas wearing diverse religious regalia is visually striking and photographs of this event are often featured on their website and in promotional materials for the training program.

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