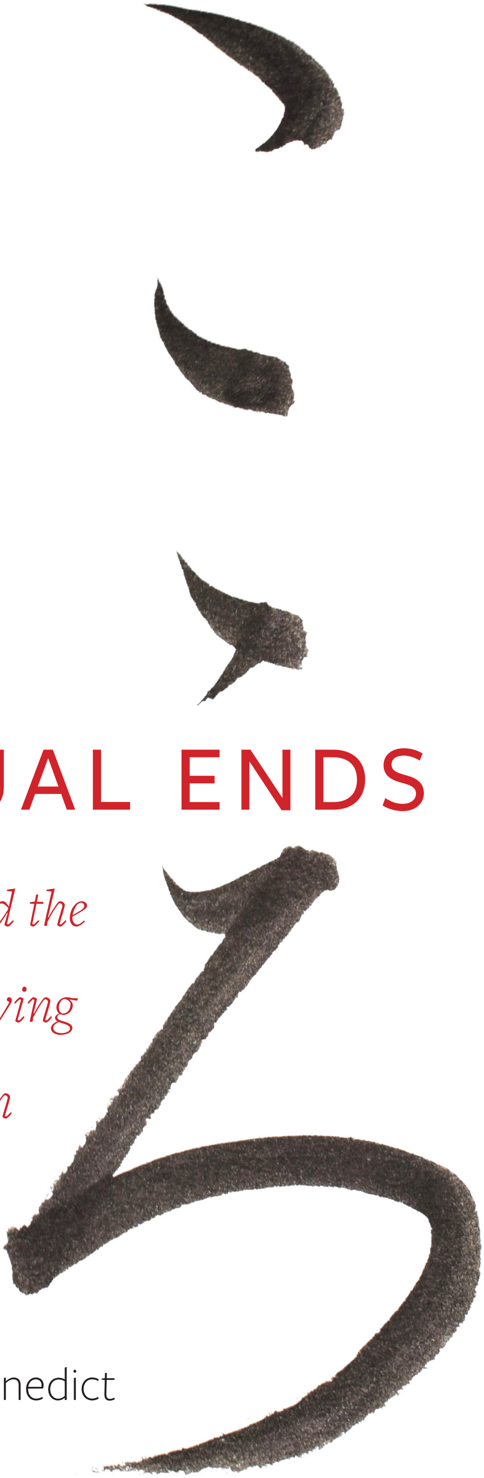

SPIRITUAL ENDS

Religion and the Heart of Dying in Japan

Timothy O. Benedict

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Spiritual Ends

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Religion and the Heart of Dying in Japan

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For Mamiko,
may you always laugh at the time to come

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PREFACE

The beginnings of this book can be traced back to my experiences working as a chaplain at a large Presbyterian hospital in western Japan between 2009 and 2011. I fell into this unusual job through an introduction arranged by a family friend, a former missionary, who worked for many decades as a hospital chaplain. Although I did not have any training in chaplaincy or prior experience in spiritual care, my job was to visit inpatients in different hospital wards and listen to their concerns; lead chapel services; and assist with hospital concerts, seasonal events, and tea gatherings in the hospice ward, alongside 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, 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 is a very ambiguous affair. Every day, I would check in at the nurses' station in 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 would softly call out a greeting from behind the curtain that separated each bed from the others, or gently knock on the sliding door of individual rooms, and then gingerly peek in. I wore the standard suit and tie issued to all the office workers in the hospital. 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 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 that lay beyond the door 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 and depart. If they were awake, I would ask, "How are you doing today?" 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 fluency (I was born and raised in Japan) and told me stories about family members who lived in or had visited the United States—the country emblazoned on my passport. Every so often, we talked about religion. Since I worked at a Christian hospital, patients would often bring up how they had attended a private Christian school or university in the past, or, how they enjoyed listening to the chapel talks that were broadcast every morning to the hospital TV sets, even though their family was Buddhist. But most patients would either preface or end their remarks by saying that personally, they were not religious.

But if most of the patients were not religious, nor particularly interested in talking about religion, why was I there? This was also a question many patients had for me. When I introduced myself as a "chaplain" (*chapuren*), many patients would query with a puzzled look: "Charlie Chaplin?" If our conversations went on for more than a few minutes, they sometimes became concerned that our chat was keeping me away from my "real" job. "Are you sure you don't have any other work to do?" I tried to explain that my job was to listen to their concerns (*nayami*). But the majority of Japanese patients—who had never heard of such a thing as a chaplain or of 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 a patient's room feeling humbled and inspired by the fortitude they displayed amid 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 stoic way 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? How should spiritual care even be defined? These questions seemed particularly germane in the case of Japan, where hospital chaplaincy is still an emerging profession. What kind of reasoning were religious groups, medical professionals, scholars, and the media drawing on to help promote this new class of spiritual care specialists? There was also the question of what kind of spiritual support patients might want. Considering that most Japanese are dedicated at a Shinto shrine as children, married in a Christian chapel, lead a mostly secular life, and have a Buddhist funeral, what role, if any, does religion play for hospice patients at the end of life? These are some of the questions that lie at the heart of this book.

In grappling with these questions, this book tells a story of how spiritual care was introduced to Japan, how it is being defined and practiced, how patients receive it, and how religious institutions and professionals are trying to shape their role in it. The primary characters in this story are hospice patients, chaplains, medical staff, religious institutions, and scholars of spiritual care. While their roles sometimes overlap, these characters all have different ideas and expectations about what spiritual care in Japan is or should be. For example, hospice patients in Japan really do not have much in the way of expectations at all. Spiritual care is an enigma to most patients, and very few are familiar with the foreign sounding concept of "spiritual care" (*supirichuaru kea*). Chaplains, in contrast, are supposed to know what spiritual care means—at least in theory. However, their approach to spiritual care is also shaped and constrained by expectations from other stakeholders in the hospice movement. These include expectations by doctors and nurses that chaplains will not abuse their position in the medical ward to impose their religious views on patients; expectations by scholars of spiritual care that hospital chaplaincy represents an exciting story of how religious groups are inventing new ecumenical and psychotherapeutic roles for themselves in the public sphere; and expectations by religious institutions that spiritual care represents an opportunity for social engagement with a Japanese public that increasingly identifies itself as "not religious."

The story of how spiritual care for the dying is being practiced and defined in Japan serves as a kind of prism through which we can gain greater analytic and descriptive clarity on religious identity in contemporary Japan.[1] 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, they are not obvious. Because much of Japan's population claims to be nonreligious, hospice workers and religious professionals who work in hospice wards across Japan are expected to draw on a very different set of practices in their care for dying patients. I draw on ethnographic fieldwork in multiple hospices around Japan to pay closer attention to how these practices are negotiated by different stakeholders in the hospice movement. I also use both local and cross-cultural perspectives to show how global conversations on the practice of spiritual care are being appropriated and reinterpreted in Japanese contexts and relate these findings to a longer story of how Japanese religious groups have pursued vocational roles in medical institutions as a means to demonstrate their "healthy" role in society. Most broadly, this book seeks to enrich conventional understandings of Japanese religious identity by paying closer attention to the *kokoro* (heart or mind) as a key site where the affective dimensions of religious and nonreligious identities are enacted.

1

Soul Searching in the Japanese Hospice

The elderly Japanese hospice chaplain leaned back in his chair and looked at me. I had just finished summarizing my research project on spiritual care in Japan. His hospice, which we had toured together, was in an airy building enfolded by greenery. From Tokyo it took about an hour by train, followed by a ride on a shuttle bus to the top of the hill where the hospice stood. It was a nice, quiet location, with a distant view of Mount Fuji framed in the large glass windows in the common room. The building, greenery, and large windows projected a space of serenity. It seemed like a good place to die. In the chaplain's office, I had my notebook and pen ready. To start things off, I asked, "What is your approach to spiritual care?" With a twinkle in his eye, the chaplain replied, "I've been working at this hospice for more than five years and I am still not doing spiritual care." He chuckled. Then what was he doing? Little did I know that he had just put his finger on what would constitute a major challenge in my research: spiritual care in Japan does not always look like what you would expect.

Soul searching suggests deep reflection. At the end of life, it evokes an image of a patient pensively staring at the walls, perhaps feeling what hospice workers call "spiritual pain." This term was popularized by Cicely Saunders (1918–2005), the founder of the modern hospice movement, who used it to describe a pain caused by a "desolating sense of meaninglessness" that accompanies the process of dying.[1] In North America, for instance, spiritual care is commonly framed as a mixture of sacramental and psychotherapeutic forms of care that focus on helping patients find religious consolation or address the existential "meaninglessness" brought about by impending death, as well as the anxieties caused by guilt, loneliness, or fear of the afterlife. Accordingly, much of the extant English-language literature on spiritual care at the end of life emphasizes strategies for responding to patients' questions about existential meaning or purpose in the face of suffering. Or it offers to guide them in a search for transcendence.[2] In the face of such spiritual pain, a hospital chaplain might come by and ask how you are doing. If you belong to a faith tradition, they may offer you communion, Shabbat candles, or prayer. More often, as the population of nonreligious patients has increased in Europe and North America, the religious dimensions of spiritual care are offered in a more fragmented or less prescriptive manner.[3] At its core, spiritual care is depicted as a "ministry of presence."[4] Chaplains are expected to "be there" for the patient and to accompany them on their spiritual journey at the end of life.

In Japan, where terms like "chaplain" and "spiritual" invite a blank stare from patients, this framework only goes so far. After all, as the elderly chaplain explained to me, only a small minority of Japanese hospice patients openly articulate a spiritual pain that is centered on existential concerns. Even fewer patients ask for religious forms of care like prayer. In fact, most of the patients that chaplains encounter in the hospice ward seem outwardly dismissive of questions about the meaning of their life, suffering, their relationship with God, guilt, forgiveness, or any other "spiritual concerns" that are typically imagined lying at the core of spiritual pain. Even when patients seem concerned about these issues, often, they would rather not show it. Instead, most Japanese hospice patients direct conversation toward other anxieties—such as a strong fear of becoming a burden on others or an inability to fulfill their social or familial responsibilities. As a result, spiritual care at the end of life in Japan frequently attends to these and other kinds of needs instead.

AIMS AND OVERVIEW

This book aims to depict spiritual care in situ, through ethnographic fieldwork and interviews with hospice patients and workers, 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 ways that they feel will meet patients' most common end-of-life needs. Spiritual care in Japan often goes beyond helping patients address their "spiritual pain" through counseling, religious support, or being a sympathetic presence. More often, spiritual care in Japan is conducted in the margins of daily care, such as through special hospice events or 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.

This is readily seen in the following chapter, "The Rhythms of Hospice Care," which focuses on the daily routines of care by doctors and nurses. I offer glimpses of the way patients are discussed during morning conferences, shadow a doctor as she does her rounds, explain how new patients are informed of their prognosis, observe how patients and their families are cared for in their last moments, and describe the intense emotional labor that medical workers must perform throughout the day. As I detail these daily rhythms of care, I pay special attention to how doctors and nurses interpret their daily medical responsibilities in relation to spiritual care, such as stressing the importance of care for the heart (*kokoro*) and helping patients "be themselves" as they approach death (*jibunrashiku shinu*).

In chapter 3, "The Heart of Spiritual Care," I turn my attention to how hospice chaplains care for patients. In Japan, chaplains at the bedside are aware that it is rare to have an opportunity to offer prayer, recite sutras, conduct sacramental rites, or candidly discuss religion and existential issues with dying patients who have never even heard of spiritual care. Accordingly, chaplains spend much of their day attending to patients in ways that go beyond traditional models of pastoral counseling, religious support, or being a sympathetic presence. I outline three broad categories of spiritual care that chaplains and other medical staff provide and argue for the particular importance of "supportive care," which stresses the importance of supporting the patient's ability to die in a way that reflects who they are. I also outline how Japanese patients and staff offer less resistance to this indirect and supportive approach to spiritual care. 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, I show that hospice staff and chaplains in fact *do* many things in offering spiritual care. While many past studies on spiritual care in Japan offer idealized models of spiritual care or demonstrate the larger religious and social contexts for such spiritual care, they often 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.[5]

It is important to interject by saying that this type of spiritual care is not necessarily unique to Japan. At many points in my research, North American practitioners of spiritual care would listen to my findings of what goes on in Japanese hospice care and say, "That sounds just like what I do." Even in societies where many patients are highly religious, such as the United States, hospital chaplains are starting to gravitate toward a kind of care that is fundamentally relational and supportive of the patient rather than explicitly religious.[6] This is exactly why the study of spiritual care in Japan has a broader global significance. As a highly secularized non-Western modern nation with a population that is aging faster than anywhere else in the world, Japan represents an important case study for understanding how spiritual care is provided to hospice patient populations that identify themselves as nonreligious.

Chapter 4, "The Meaning of Spiritual Pain," pivots from caregivers to patients by scrutinizing spiritual pain—the clinical term that refers to the existential suffering that dying patients are said to experience in the face of death. By collating interviews with hospice patients, I examine several reoccurring themes in the types of anxieties dying patients face at the end of life and where they turn for support. I then show how the anxieties Japanese hospice patients voice call into serious question the clinical category of spiritual pain, even while, in some cases, they support it. Many Japanese patients are unlikely to openly express their anxieties in religious or existential terms. Nevertheless, there remains a fundamental tension in the concept of spiritual pain because chaplains suggest that spiritual pain can also be latent, repressed, or sometimes just poorly articulated by Japanese patients. This shows 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 genuinely believe that spiritual pain can be manifested in subtle ways that elide the clinical gaze.

This book also uncovers how Japanese hospice workers and scholars of spiritual care are soul searching—quite literally—to define the nebulous concept of spirituality. The most basic question that spiritual caregivers in Japan grapple with is, "What is spirituality?" The English word "spirituality" is usually left untranslated and simply transliterated into Japanese *kana* syllabary as *supirichuariti*. In recent years, many studies have been published by Japanese hospice workers and scholars that aim to delineate the spiritual from the physical and psychosocial dimensions of hospice care.

In chapter 5, "The Invention of Japanese Spirituality," I explore several such definitions of spirituality and spiritual pain and show how these studies invariably present spirituality in clinical settings as a discrete dimension of personhood, which resides in all patients and becomes awakened in the face of an existential crisis like death. This medicalized view of spirituality echoes the World Health Organization's definition of palliative care, which distinguishes between the spiritual, physical, and psychosocial dimensions of personhood. However, I suggest that these efforts to define spirituality in hospice care tend to ignore the diffuse ways in which hospice workers actually attend to the spiritual needs of patients in practice. By critically engaging with the invention of the term "spirituality" in Japan and looking at how this ambiguous concept has been applied in clinical settings, I demonstrate the way the term "spiritual" and its cognates work as floating signifiers; they primarily function as negotiable boundaries. That is to say, they help different stakeholders in the hospice movement to maintain or contest the acceptable parameters of religious care for dying patients. I also detail how this search for spirituality is part of a global conversation in which both Japanese and other understandings of spirituality are being transposed and reappropriated across cultural boundaries. Ultimately, I suggest that spiritual care in Japan is better described as a type of care for the *kokoro*—a concept with less historical baggage that also better captures and illustrates the importance of the affective dimensions of religious practice and identity in Japan.

A final aim of this book is to show how contemporary Japanese religious groups, and especially contemporary Buddhists, are looking to spiritual care as part of the answer to the ongoing soul searching about their role in Japanese society. Statistical indicators of Japanese religiosity have consistently shown the declining importance of religion in Japan.[7] After the new religious group Aum Shinrikyō carried out a sarin-gas attack in the Tokyo subway system in March 1995, many Japanese came to view religion with deep suspicion. In the aftermath of this attack, which claimed thirteen lives and injured over six thousand others, public trust in religious organizations was deeply eroded.[8] 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.[9] Today, when I ask my Japanese university students (who were all born after the Aum attack) what the word "religion" means to them, they regularly respond with adjectives like "scary" (*kowai*), "suspicious" (*ayashii*), and "creepy" (*kimoi*). This generally negative impression of religion has been a consistent feature of Japanese society for at least the past two decades, if not longer. As Japanese religions have seen their public role and prestige in society shrink, for Buddhists in particular, there has been much handwringing about being pigeonholed as nothing more than funerary specialists.

In this context, a small but growing number of Buddhists have come 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.[10] For religious professionals in Japan more broadly, including Christians and members of new religious groups, the establishment of new vocational roles in hospitals, a paradigmatic modern social institution, represents a potential avenue to dispel the suspicions and preconceptions many Japanese harbor toward organized religions. Care for the *kokoro* represents an opportunity to demonstrate the positive role religion can play in Japanese society. However, this soul searching on the part of religious professionals is by no means new. Rather, as I demonstrate in chapter 6, "Making Healthy Religion," the vision of promoting spiritual care in the hospice is embedded in a longer history of religious engagement in modern medicine, dating back to the late nineteenth century, that reveals a persistent attempt on the part of modern Japanese religious groups to show the "healthy" role that religion can play in society.

This book begins by describing the day-to-day nuances of spiritual care and then sequentially zooms out to situate spiritual care in its broader theoretical and historical contexts. The details on the daily practice of spiritual care in chapters 2, 3, and 4, which are primarily ethnographic, will not only appeal to scholars and students of Japanese religion, but also to healthcare practitioners around the world with an interest in what spiritual care looks like on the ground in Japan. Chapter 5, which examines theoretical discourse on spiritual care in Japan, offers a deep dive into debates about the dividing lines between religion and spirituality from the perspective of Japanese clinical and academic literature on spiritual care. This chapter will appeal to chaplains engaged in spiritual care as well as scholars interested in critically interrogating the application of "spirituality" in health care settings. Chapter 6, which documents the history of religious engagement in medicine and the birth of hospice care in Japan, may be of particular use to those with an interest in the history of socially engaged Buddhism as well as the historical relationship between religion and medicine in Japan more broadly. Chapter 7, "Last Thoughts," tries to bring this all together.

THE NEED FOR HOSPICE CARE IN JAPAN

Japan is currently in the midst of a dramatic demographic crisis with profound implications for its society. As of 2020, 28.7% of Japanese were aged sixty-five or older—the highest percentage in the world.[11] 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.[12] This rapid aging is driven by Japan's low birthrate, which currently hovers at about 1.4 births per woman. This number actually represents a slight improvement over an even lower rate of 1.2, which was recorded between 2003 and 2005. Although the Japanese government has worked urgently to institute various policies that encourage families to bear more children, these have only been marginally successful, and the birthrate remains well below the replacement fertility rate of 2.1. Accordingly, Japan's total population is expected to decline by about forty million people, from its peak of 128 million in 2008 to approximately eighty-eight million in 2065.[13] This progressive graying of Japan's population has already begun to put extreme pressure on families who must care for their elders at the end of life.[14]

The growing need for hospice care in Japan is not only tied 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.[15]

Even still, the resilience of traditional family structures in Japan are being tested today 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 low birth rate, there are simply 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, this task has become increasingly onerous, as the number of married women who choose to remain in the workforce has grown. Moreover, if a daughter-in-law is an only child, she is likely to be held responsible for the care of her own parents as well. In rural areas, where depopulation is particularly acute, the problem is compounded by a lack of job opportunities that would allow children to return to their hometowns. 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. 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 their elders 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 between the ages of forty to eighty-nine. In 2019, 4.3% of Japanese cancer deaths occurred in a nursing home, 12.4% at home, 69.9% in a hospital or clinic, and 13.4% in a hospice. Although only slightly more than a tenth of cancer deaths currently take place in a hospice, this number is trending upward. For example, in 2000 only 2.5% of cancer deaths occurred in a hospice and 90.6% of cancer deaths took place in a hospital.[16]

There are many benefits to dying in a hospital. First of all, it is convenient. In fact, dying in a hospital may be the only realistic option for those who live in rural areas with no hospice care nearby. Dying in a hospital also ensures that patients retain access to life-extending treatments until the very end. Having full access to a range of diagnostic and treatment services is no small consolation for patients who wish to extend their life as long as possible. For example, one patient I met during my fieldwork 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 cancer until the very last minute was important for her. Refusing to go gently into the night helped her cope with death.

However, for most patients, dying in a hospital is far from ideal. This problem was laid out most clearly by Yamazaki Fumio in his 1990 bestseller *Dying in a Japanese Hospital*, which was later made into a film. Yamazaki shares the stories of five patients who died horrible medicalized deaths, contrasted with five patients who died dignified, humane deaths, and argues that Japanese hospitals were too focused on treating the disease at the expense of the person. Yamazaki describes an interaction between one patient and his doctor: “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.”[17] Yamazaki concluded by calling on medical workers to treat patients more holistically, with fewer medical interventions, with fuller and more honest prognosis disclosure, and to make spiritual care available to all patients. Basically, he called for more hospice care.

FIGURE 1. A tatami-mat hospice room (Photo by author).

WHAT DOES HOSPICE CARE LOOK LIKE?

The word “hospice” stems from the Latin *hospe*, meaning “hospitality.” It originally referred to places of shelter that religious orders in medieval Europe provided to travelers and the sick.[18] Medieval European hospitals were religious houses that were built as spaces where the soul could be cared for, where illness-generating sins could be removed, and the pious could exercise charity. Care for the immortal soul was therefore paramount in importance—much more so than care for the mortal body.[19] Religious care was therefore integral, if not foundational, to the mission of medieval hospices.

Many centuries later, the first modern hospice, Saint Christopher’s Hospice, opened its doors in London in 1967 under the leadership of Cicely Saunders, a Christian nurse, social worker, and physician. In Japan, the first hospice ward opened in 1981 at a Christian hospital, and many more were established after palliative care came under the aegis of Japan’s national health insurance in 1990. As of 2020, there was an estimated 453 palliative care wards in Japan. On average, each hospice has about twenty beds, and in 2019 the average length of stay was 28.5 days.[20] Officially, hospice care is described in the regulations of Japan’s Ministry of Health, Labour and Welfare as “palliative care” (*kanwa kea*), and this term is used interchangeably with the more traditional term “hospice” (*hosupisu*) in the popular media.[21] I rely on the more popular terms “hospice” and “hospice care.”

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*). This type of hospice is by far the most common and represents 85% percent of Japanese hospices. The second type represents about 13% percent of hospices, and are located in a separate building on hospital grounds (*innai dokuritsu*). 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 allowing patients to smoke without falling afoul of hospital regulations. A third type of hospice, of which there is only a handful, exists independently from a hospital (*kanzen dokuritsu*). A fourth type of hospice care includes palliative-care teams (*kanwa kea chīmu*) that are assembled within a larger hospital to treat cancer patients who are scattered across different wards. In 2017, nearly 15% of Japan's 7,353 hospitals had such teams in place to help treat terminally ill patients.[22] Finally, home hospice (*zaitaku kanwa kea*) is provided by a growing number of small clinics and home-visit nursing stations that help care for Japanese cancer patients who prefer to die at home.

This study focuses 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. I also refer to some hospices as Buddhist, Protestant, or Catholic. Buddhist hospices are sometimes referred to as Vihāra wards and chaplains are called Vihāra priests. The term *Vihāra* means "abode," and traditionally refers to monasteries, retreats, or places of rest. This term was coined to provide an alternative to the word "hospice," which carries Christian associations.[23] These religious hospices and Vihāra wards were founded by religious groups that continue to uphold the spirit of their respective denominations in their mission statement and in the provision of religious services, materials, and spaces to patients who request it. But this does not mean that those who work in such hospices are necessarily religious. Hospice staff might occasionally happen to share a similar religious background as that of their workplace, but since most hospitals face a constant shortage of nurses and doctors, the religious mission of the hospice usually has only a slight bearing on who is hired. The same goes for patients. On occasion, patients may seek to enter a hospice that complements their religious views, especially in urban areas where different choices are sometimes available. However, long waiting lists typically preclude such choosiness and so selecting a hospice based on availability and location is usually a much stronger determinant. It is not strange at all to hear of devout Buddhist patients being cared for in a Christian hospice or a devout Christian being cared for in a Vihāra ward.

Although all members of the hospice team in Japan are expected to practice spiritual care, the primary givers of spiritual care in hospice settings are chaplains. Most chaplains are either ordained or have some form of religious training and background, but this is not always required.[24] Because most Japanese hospice wards are located within a larger hospital system, the chaplains' work in the hospice may represent just a small portion of their daily responsibilities. Visits to the hospice 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, a Lutheran pastor visited just twice a month. At another hospice, a Catholic chaplain visited patients once a week while also teaching part-time 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, but only when necessary. In hospices that maintain a strong religious affiliation, however, a chaplain typically works full time.

The exact number of hospital chaplains currently serving in Japanese hospice wards 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 sixty-eight different palliative care wards around Japan at that time.[25] However, another study estimated in the same year that there were only sixty chaplains at thirty-seven hospice institutions.[26] According to the Hospice Palliative Care Japan Website, in 2017, at least fifty-eight of their 331 member institutions provided some sort of spiritual care to patients or their families through religious workers or volunteers.[27] Finally, a 2020 survey of 368 hospices reported that thirty-four hospices (11%) employed at least one part-time or full time chaplain, while a further sixteen hospitals (5%) employed two or more chaplains. Based on these numbers and my own fieldwork, I estimate that there are currently just over one hundred hospice chaplains who are actively engaged in providing spiritual care on a near to fulltime basis in Japan.

UNDERSTANDING SPIRITUALITY

In Japanese, the word "spiritual" (*supirichuaru*) 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. The English 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*; Lt. *spiritualis*) is contrasted with the "flesh" (Gk. *sarkikos*; Lt. *carnalis*). A spiritual person referred to someone who walked according to the "spirit of God" instead of pursuing his or her own fleshly desires.[28] In the centuries that followed, the word took on a number of new associations, referring, for example, to something that contrasted 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.[29]

This spiritual realm remains notoriously vague as a category of analysis. Courtney Bender, for example, likens her research on American spirituality to "shoveling fog."[30] Spirituality is equally—if not more—vague in Japan. While a fuller genealogy of the term "spiritual" in Japan will be examined later, here, at the outset, I simply make clear its etymological baggage and emphasize that I do not desire to generate any additional definitions. Rather, my interest in the spiritual is genealogical. I seek to explain how its meaning is negotiated in Japan by different actors in different contexts for different purposes.

A key finding by religious scholars in English-language scholarship is how the term "spiritual" primarily serves to mark boundaries when faced with a diverse range of religious and nonreligious beliefs and practices. Ultimately, I suggest that the use of the term "spiritual" in Japanese hospices also 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 previous scholars who point out that spirituality it is not merely a flawed scholarly category, but scarcely an objective category at all.[31] Rather, I seek to emphasize its growing importance as a component of contemporary religious discourse in Japan. In doing so, I also pay special attention to how the popularization of the term "spiritual" in hospice care can sometimes be at odds with an understanding of the *kokoro* (heart) as a key area where Japanese religious identity is enacted.

By taking a step back and observing how the term "spirituality" is used, it is also easier to see the competing interests that lie behind attempts to care for a patient's spiritual pain. 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. As John Lardas Modern points out, the language of spirituality often functions as a new rhetorical device, or grammar, that expresses individual intentions within, against, or alongside religious institutions.[32] In other words, spirituality is not really an ontological thing, but rather describes a way of going about things. 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, spirituality emerges as a discursive shadow that helps to mark claims against, for, or alongside religion. Accordingly, I attend to the way the hospice functions as a space where different stakeholders negotiate the range of meanings that orbit around the concept of spirituality. Ironically, my approach parallels the proclaimed ethos of hospice care itself, which calls attention to the whole person. That is to say, instead of isolating patient spirituality in hospice settings as a discrete object of analysis, I hope to examine it holistically.

By studying spirituality as a manner of language that seeks to draw boundaries between religion and the secular, recent English language scholarship on spirituality also continues to challenge the way some scholars of religion still lapse into using the term "spirituality," as if the meaning of the term was self-evident.[33] 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.[34] 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. The danger in reproducing this binary between spirituality and religion, however, is that such statements can sound awfully smug. Herman playfully points out that 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. Definitions of spirituality ultimately project "modern, western, cosmopolitan, religiously liberal values" such as "individualism, interiority, privacy, and non-dogmatic progressivism."[35] In this way, even ostensibly academic studies of spiritual care can wind up celebrating spiritual care as emblematic of the potential for a less rigid, individualistic, ecumenical, and nondogmatic form of religion.[36]

This view helps reveal the way scholars of spiritual care in Japan also sometimes take the term "spiritual" for granted or even unwittingly celebrate it.[37] By contrast, I 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 celebrating it. Rather, even while fully acknowledging the importance of providing spiritual care for patients in hospice settings, I also show how clinical appropriations of the spiritual reflects an ongoing definitional project by religious professionals to help negotiate their position within Japanese healthcare settings. In this sense, my approach to the topic of spirituality in Japan resembles other recent scholarship on the category of religion in Japan in that it is constructivist.[38]

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 my hospital's motto of "whole person healing" (*zenjin iryō*), that was originally established by the Presbyterian missionaries who founded the hospital with the aim of serving patients as a total unity of body (*karada*), mind or heart (*kokoro*), and spirit (*tamashii*). 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 what lies at the heart of spiritual care.

The methodological challenges of this study are in many ways akin to that experience in that while I am ostensibly recording a fascinating discussion, I am also contributing to it. Although this study seeks to distinguish itself from some of the normative approaches to spiritual care taken by clinical workers and scholars of religion interested in promoting it, an honest ethnographer knows that complete detachment is a chimera. For example, my fundamental interest in the study of religion has already been shaped in important ways through my experiences growing up as the child of second-generation Protestant missionaries in Japan. My role as a researcher of spiritual care is further complicated since I previously worked as a hospital chaplain. In this regard, staying reflexive about how my own background influences my research is indispensable to dispelling the longstanding myth of a neutral disinterested scholar.[39] Holding a perspective that elevates myself as more informed and clearsighted about spiritual care than the subjects I interview can itself be just as normative a construction of meaning as any wild thing my informants say.[40] However, while my background certainly colors my perspective on spiritual care, it was also indispensable for conducting my research in the first place. Without growing up in Japan and having worked as a chaplain, it would have been next to impossible to gain unfettered access to hospice patients. Thus, while I do not intend to (and cannot) erase my own role in helping construct the way spiritual care is both understood and practiced on the ground, my ultimate goal is still the same. I want to reflect on the big picture to see what the practice, language, and history of spiritual care can tell us about the role of religion in medicine and about religious identity in Japan today.

In terms of the scope of my fieldwork, I utilized a multisited approach. One of the primary drawbacks of this method 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.[41] Most of my fieldwork took place during three summer visits to Japan in 2012, 2013, and 2017 and fourteen months of concentrated fieldwork between 2014 and 2015. During that time, I spent time at twelve hospices in Japan as well as three in Taiwan (not addressed in this study), including two weeks of participant observation at a Catholic hospice, two weeks at a Protestant hospice, and two weeks at a Buddhist hospice. I also visited the Protestant hospice on a weekly basis for six months to interview patients. Besides participant observation and informal conversations with patients and staff during my fieldwork, I also conducted recorded interviews with twenty chaplains, eleven doctors, twenty-five nurses, and nine hospice patients in Japan as well as additional interviews with several doctors, nurses, and chaplains in the United States and Taiwan. All the names of patients and hospice staff I interviewed have been made pseudonymous. Japanese names are given in the traditional way, with the family name first. I also refer to patients with the polite suffix *-san*, which reflects the actual way I addressed them.

Gaining access to dying patients for research is no easy task. Privacy is sacrosanct in medical settings and hospice staff are understandably very protective of their patients. Patients were made available to me based on their willingness and ability to talk and were by no means "typical" hospice patients. A typical patient could not be interviewed due to sedatives they were taking, their weak state, the onset of dementia or delirium, or a lack of strength to voice words. Even for those who were in relatively better condition, their level of pain and energy could fluctuate quickly. For formal interviews, I excluded all patients who had overt pain, difficulty talking, dementia, or who were emotionally fragile. This could mean that, for many weeks, no one was available to talk. 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, or agree to be interviewed but then decline just moments before I arrived. The practical and ethical challenges of gaining access to patients were most cogently driven home after I finished my very first patient 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.

Due to the unique challenges I faced in gaining access to hospice patients, I have not attempted to construct statistically significant claims about how Japanese hospice patients articulate their concerns at the end of life. Even if a 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. At the same time, 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."[42] In other words, the specificity of each patient's experience tells us something about the world in which they are embedded. Accordingly, the patients I interviewed are not necessarily representatives of wider patient types. Rather, each case highlights a notable feature of how hospice patients deal with death that helps us understand their cultural, social, and religious environment that is shared by other patients as well.

I also refrained 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.[43] 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 the inherent challenges of an outside researcher approaching hospice patients made qualitative description the most suitable tool to use.

I was fortunate in that after clearing my research with both institutional review boards and ethics committees in the United States and at each institution in Japan, I was able to leverage my many years spent living in Japan and past experiences as a chaplain to gain access to patients. This was a great privilege. Accordingly, I have endeavored to make their voices a focal point of this study. As I listened to their audio-recorded voices on my computer long after they were gone, I felt a heavy responsibility to get their stories right. I can only say that I tried my best.

2

The Rhythms of Hospice Care

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 rear of the room connects this examination room to others. By leaning back and peering to my left, I can see a 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 the family 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 their hospice has two kinds of rooms: one type is free of charge but on the small side, the other type is larger but comes at an additional price. The wife and daughter interrupt him: "Either one is fine . . . please, whichever is available sooner, even if there is a charge."

"Okay, I will contact you again when a room becomes available."

The wife rises up from her stool 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. 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 comes back in and sighs, "It's looking grave [*kibishii*]."

ENTERING THE HOSPICE

In Japanese, the word *kibishii*, 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*), "relieved" (*hotto*), "at ease" (*raku*), and even "healed" (*iyasareta*). 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? Should they 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 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 called 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*]. I have no complaints.

As Higashimoto-san explained, one of the hallmarks of hospice care in Japan is helping dying patients feel a deep sense of calm in the days leading up to their death. While many of the day-to-day activities in the hospice are centered on palliating the patient's physical pain, the next important thing they can do is to help patients "be themselves" as they approach death (*jibunrashiku shinu*). But of course, it is not easy. Great emotional labor is involved. As nurses and doctors interact with a wide variety of patients at different stages of their illness, hospice workers are required to manage their emotions in front of patients and their families to demonstrate how much they care for and value the person dying in front of them. Good bedside manner is fundamental to all medical practice, but is felt to be particularly important at the end of life when patients feel especially isolated and may doubt the worth of continuing to live. This broad care that empathizes with and supports the heart of the dying is commonly referred to as *kokoro* care.

KOKORO CARE IN THE HOSPICE

Kokoro, a word that signifies the mind, the heart, the will, and much more, is notoriously difficult to translate into English.[1] It also commonly serves as a referent to the "self." For example, the phrase *kokoro bosoi*, meaning to feel lonely or without support, literally means "thinning of the heart." References to the *kokoro* is ubiquitous in Japanese culture, and in new religions, for instance, where the *kokoro* is the site of self-cultivation, an object to be purified, and a source of power.[2] In the Buddhist context, the *kokoro* is often treated as the locus of moral personhood. For example, in Japanese prison chaplaincy, the *kokoro* becomes a source of trouble through neglect; it is something that needs to be rectified or healed. Accordingly, Buddhist prison chaplains interpret the crimes committed by the incarcerated as bad karma, and their job as chaplains is to rectify the *kokoro* of the prisoners they work with to help expunge the bad karma.[3]

The importance of the *kokoro* as a site for religious sensibilities has become more apparent in contemporary Japan as many have shunned religious language that feels threatening. This is seen, for instance, in one of Japan's longest-running national television programs, *The Age of Kokoro: Religion/Life* (Kokoro no jidai: Shūkyō/jinsei). This program, which began in 1962, was originally named *The Time for Religion* (Shūkyō no jikan); it changed to its present name in 1982. The weekly program features interviews with religious figures, philosophers, social activists, educators, and on many occasions, hospice workers, to discuss religious wisdom and celebrate stories of human resilience and the overcoming of life challenges. As Mitsutoshi Horii points out, the replacement of religion (*shūkyō*) with *kokoro* in the program's main title represented a softening and broadening of religion, which was likely made with the intention of extending the scope of its content and viewership. Horii also notes that while only 28% of Japanese surveyed in 2013 affirmed that they had a specific faith or belief, 66% felt that it was important to have a religious *kokoro* (*shūkyōteki na kokoro*).[4]

In hospice care, however, caring for the *kokoro* takes on a different nuance. It usually means to simply treat the patient as a person—in other words—holistically. It means to look beyond a patient's physical or medical needs. It refers to a care for the inner self, which includes both the mind and spirit. In theory, *kokoro* care is broader than spiritual care since the latter is focused on care for the "spirit." In my interviews, chaplains, nurses, and doctors all agreed that *kokoro* care denotes a broader set of practices that provides the foundation for spiritual care. But in practice, *kokoro* care also effectively doubles as spiritual care. While spiritual care is traditionally associated with care for a patient's religious or existential pain, in the absence of such symptoms hospice workers often focus on caring for the *kokoro.*

INITIAL EXAMINATION

Since most hospices in Japan have a long waiting list, a new hospice patient is received almost immediately after a bed opens. Shortly 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 and lungs, examine the patient's eyes and mouth, and check the feet for swelling to measure blood circulation. Next, if the patient is still capable of speaking, the doctor will ask a number of questions, like: "What hurts the most?" "On a scale of one to ten, how much does it hurt?" "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 patient'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.[5]

One technique I observed of broaching the subject of informed consent with patients in Japan involved 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*]. Which type of patient are you?" Answering this question is not always easy. For example, 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 . . . [here, 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 the initial meeting with a new patient, hospice staff excuse themselves from the room and meet with family members separately. At this time, 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*) to her caregivers. She did not even mention the pain from her bedsores until her sister discovered them. The family also explained that Kaneda-san felt guilty about dying before her father, 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 once told her family that she was giving 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 her condition was very *kibishii*. As the patient's father and sister continued to sniffle, the doctor tried to end the interview on a positive note by explaining again how the staff would be doing their utmost to make sure she didn't experience any physical pain during her stay. Medical control of her physical pain was one of the few promises the doctor could make in light of the many unknowns about how the short remainder of Kaneda-san's life would unfold.

Controlling physical pain is always the first priority of hospice staff. The founder of the modern hospice movement, Cicely Saunders, once explained that if she were a patient in 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."[6] 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.

In some cases, however, physical pain can also be a source of what appears to be 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 professionals involved in spiritual care, suggested 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, 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 first shift report (*mōshiokuri*) in the hospice typically takes place around 9 a.m. The doctors, nurses, pharmacist, social worker, and chaplain gather in a room adjoining the nurse station while the night shift rattles off a rapid-fire report on the patients' conditions and whether anything notable occurred during the night. The patients' names are neatly arranged on a printed handout. The handout also lists the type of cancer they have right next to their name. Everyone looks down at their patient list as the nurse speaks.

> *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 her husband's recent death. 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 okay 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' physical symptoms, occasionally, there is an extended discussion of other issues. For example, staff members 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 visited 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 later discussion during the workday or in private exchanges. As nurses return to the staff station after the report, there is often an outpouring of conversation as they informally exchange information about patients or pull a doctor aside to discuss a specific issue.

The next time the hospice team gathers together 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 or evening shift reports. 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 use these meetings to 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 seemed distressed and repeatedly asked the staff to raise her sedation levels and to "let me sleep" even though the amount they had given her was appropriate for her pain. Suspecting a deeper reason behind this request, the nurse consulted with the chaplain who initially expressed hesitation about raising her level of sedation since there seemed to be no obvious medical reason. He worried that she might be relying on the sedatives to overcome some sort of spiritual pain. Raising her sedation would also mean fewer chances for her to converse with her family. But when they consulted with 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 command of a situation and the adjustment of her medication was one of the last ways she could exert control over the end of her 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 "was not herself." Ultimately, the doctor agreed to slowly raise her sedation level and she passed away shortly after that.

The staff at the afternoon conference now discussed whether raising her sedation levels had been the right decision. The chaplain stated that in light of Fukuda-san's wishes, he ultimately 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 oversedation—an action he would normally oppose. Rather, it represented a situation where the patient simply wanted to *be herself* by retaining control over her treatment until the very end. In this case, the chaplain argued, it made sense to respect her wishes and allow her to receive a deeper sedation even if her physical pain levels did not warrant it and it could mean fewer opportunities for communicating with her. Another doctor reaffirmed how Fukuda-san was an exception to the principle of not sedating patients without an underlying medical reason. He was careful to point out that sedation should never be used by staff to avoid the discomfort of watching a patient suffer spiritually. 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.[7]

The case of Fukuda-san illustrated how spiritual care could potentially be at odds with other types of care. For example, if she was tired of wasting away in bed and simply wanted a higher level of sedation to forget her daily misery, most staff would rightly feel uncomfortable acquiescing to her request. If the true issue was physical discomfort or pain, it may have been reasonable to help her "sleep." But from the perspective of hospice workers who are committed to spiritual care, sedating her without medical reason might have failed to address a potential spiritual pain that might be 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 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, a female patient in her seventies, whose hands and feet, as we had just learned during the morning shift report, were getting colder. This was not a good sign. When we entered her room, we could immediately see that her breathing was labored. 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 medications by IV." She gently uncovered the patient's feet and felt them in her hands. "Still warm." She then addressed Arima-san 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?" Dr. Kuroda replied, "I'll explain later."

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 are not in pain and try to comfort the family by letting them know that despite their appearance, they are 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 nurses' 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 asked what medications she was giving Arima-san. "Mostly morphine," Dr. Kuroda replied. She was also on another medication to help with 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. They could stop breathing (for example, in the case of lung cancer), which was then followed by cardiac arrest. Arima-san was likely to follow this pattern. Or they slowly weakened to the point that they could no longer eat. In some cases, when a patient has ascites, dying may take even 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 entirely off the fluids produced by his body. Most doctors prefer to stop giving food and liquids to patients at the end, since it causes them unnecessary pain. The nutrients often go straight to feeding the cancer anyway. Drinking liquids can also increase 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 getting weaker without food or water.

Dr. Kuroda went back to Arima-san's room and motioned to the husband to join her in the hallway. She asked when his son would arrive. "He's on his way," he replied. She then addressed the possibility of a sudden turn in his wife's condition. She explained that at this stage, a change for the worse could happen at any moment 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, "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," he said. "I'll 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 can really take a long time." When we entered her room, Kuribayashi-san was reclining on her bed with an oxygen tube under her nose. In contrast to Arima-san, she was very 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 use the internet to order various things she fancied. She sometimes even ordered takeout meals to be delivered to the hospice, including from Mos Burger, a Japanese hamburger chain. This resulted in much laughter among the staff, since nobody in the hospice had any idea that this particular restaurant chain did deliveries. On another occasion, she purchased several large electric hotpots online and then invited the hospice staff to join her for a hotpot party in her room. A photo of the party was pinned to the bulletin board by her bed, next to several other photos taken during the hospice Christmas party. 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, but relaxed once she heard that I was fluent in Japanese. She began chatting about when she first saw Americans after the Second World War. She was a teenager when the war ended and she recollected how at the time, pretty girls were told to smear charcoal on their faces so that 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 learned a few English phrases as a girl during the American occupation, including: "I can't speak English." As I complimented her on her pronunciation, she noted that without a language barrier, foreigners felt much closer. As a matter of fact, she admitted that I was the first foreigner she had ever spoken to. Inside, I knew I was also 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 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 on her bed. Her brother and sister sat 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 pink color. The bright nails stood in stark contrast to her gaunt frame and drawn skin. Her mouth was involuntarily 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; with every inhalation she made noises in her throat. Her family was becoming quite teary. We left the room.

HELPING PATIENTS FEEL VALUED

And with that, the morning had come to an end. Dr. Kuroda went to her desk to eat lunch, and I went to the cafeteria downstairs. As I admired the lunch of the day, a bowl of steaming rice topped with tasty tempura, 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 feelings while going so quickly from one room to another? I remembered the advice I had received when I worked as a chaplain. "Before you go into a new room, take a moment and clear your mind of your visit with the previous patient. You don't want to bring your feelings from a prior patient into the room with you."

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."[8] 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. Hospice workers also engage in this type of intensive emotional labor—only the stakes felt higher. Dr. Kuroda's ability to shift from 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 *kokoro* care is largely about *how* one engages with patients, emotional labor becomes indispensable to its practice.

Although hospice doctors and nurses spend a good part of the day helping to alleviate physical pain, ensuring that patients are comfortable, and communicating with family members, this is not to say that they do not see themselves as also providing *kokoro* care at the same time. 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, were seen as important ways to let the patient "be themselves." This in turn communicated to the patient that they were highly valued and that their lives still had meaning—a kind of *kokoro* care. Doctors and nurses also tried to use small talk and compliments during their rounds to foster intimacy with patients, letting patient concerns resonate in their hearts. Other times, they would just sit for a time next to semiconscious patients and stroke their hand as they struggled to breathe. As one veteran nurse explained, "Even now, when I get questions from patients, 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."[9] Or, as one doctor put it, the most important principle of spiritual care was simply to "turn one's eyes to the patient's suffering and to listen to them."[10] Another doctor suggested the importance of "letting the patient know that their existence is an indispensable necessity to you" (*hitsuyō fukaketsu na sonzai*).[11] In short, for many medical staff, the practice of spiritual care essentially meant communicating how much the patient meant to them. This communication was sometimes practiced directly, but more often indirectly, as hospice staff went about their daily duties mingling *kokoro* care in the interstices of other forms of care.

This understanding of spiritual care appears broader in definition than the more religiously inflected forms of spiritual care such as prayer, provision of religious services and sacraments, or encouragement through scripture. But since most Japanese patients are not very religious anyway, showing the patient how much they are valued through *kokoro* care was seen by most doctors and nurses as essential to the practice of spiritual care. *Kokoro* care was not seen as a substitute for a kind of spiritual care that was predicated on a religious approach, but rather was a part of it. This close connection between the *kokoro* and the religious dimensions of hospice care can be traced back to the early days of the Japanese hospice movement, when the religious dimensions of hospice care were even featured in the news media with reference to their ability to provide "*kokoro* care," as well as "*kokoro* support," and "*kokoro* medicine."[12]

SAYING GOODBYE

No sooner had I finished reflecting on the morning when one of the doctors peeked into the cafeteria, motioned to me, and curtly said, "It's time for final care" (*ima, mitori*). I quickly returned to the ward and found Dr. Kuroda at the nurses' station. She was just about to go look for me. Arima-san had passed away. The nurse explained to us that as Arima-san approached the end, it looked to those in the room that she had mouthed the word "water," and so family members took turns swabbing her mouth.[13] About twenty minutes later Arima-san stopped breathing. I now went with Dr. Kuroda and the nurse into her room. It was filled with her family: her husband, children, and their spouses. Everyone was weeping. 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 gently: "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 from the waist to the patient for about ten long seconds. After bowing, Dr. Kuroda addressed the now silent patient one final time. "You did a great job. Thank you for your hard work." The nurse then encouraged the family to surround the patient and say their goodbyes. As we left the room and walked back to the nurses' station, both Dr. Kuroda and I were silent. 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 often simply notes that they have been "discharged" (*taiin*) from the hospice. For most patients, death is the only way leave the hospice behind for good. Only the power of death can stop their cancer. 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*). This ceremony is optional, but many families welcome it. The ceremony is usually held in the patient's room or in the hospital mortuary (*reianshitsu*). At Christian hospices, it may also take place in the hospice chapel in the rare case that the patient was a Christian. At a Buddhist hospice I observed, the ceremony was held in a room called a Vihāra hall, which contained a Buddhist altar. For example, of the seventy-eight patients who died between April 2010 and August 2011 at this Vihāra ward, forty-eight (63%) of families requested a goodbye ceremony.[14] But this also depended on the time of day when they died. Eighty-nine percent 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. During this ceremony, the patient's bed was placed in front of the Buddhist altar. A favorite item of the deceased, such as a family photo, was also placed on the altar. On one occasion, a 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 a hymn, such as "What a Friend We Have in Jesus" (Itsukushimi fukaki), while at Buddhist hospices, priests will recite a sutra.

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 company 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.

LEAVING THE HOSPICE

As the funeral workers wheel the patient outside to the hearse, I join the hospice staff who quietly stream behind the rolling stretcher. When we exit the hospice doors, we are blinded for an instant by the bright sunlight, and I try not to sneeze. The patient has been covered with a special quilt that was made by hospice volunteers. The funeral workers take the quilt off the patient and replace it with their own blanket. Just as they lift up the quilt, however, 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 folded quilt back to the hospice staff.

They load the patient 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 looks confused about 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 hot sun reflecting off the white rounded backs of the doctors and nurses in their uniforms before me.

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, he instead bows deeply to the staff. We all bow in return, 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.

Once the patient has left the hospice, he or she is then transported by the funeral company to a funeral parlor or the family home where the body is washed and nicely clothed. This is followed by a wake and funeral conducted by Buddhist priests, unless the family belongs to another religious tradition, or prefers a nonreligious ceremony. After the funeral, the body is taken to the crematorium and the ashes are eventually deposited in a grave at the family temple, or increasingly, in new communal ossuaries that are cheaper and more convenient. Memorial services at later dates are also handled by Buddhist priests.

After their final bows outside, there is usually little further interaction between the hospice staff and the family. If the patient spent a long time in hospice care, the family may visit the hospice again after some time has passed to show their thanks. Some hospices also arrange for yearly events where family members of patients who had passed away in the previous year can reunite with staff and reminisce together. Hospices sometimes cooperate with volunteer organizations to help arrange more regular gatherings for grief care as well.

THE AFFECTIVE DIMENSIONS OF SPIRITUAL CARE

Kokoro care in the Japanese hospice shows the importance of the affective dimensions of spiritual care. Although some patients do not hesitate to bring up cognitive questions that relate to an existential search for meaning in the face of death, the practice of spiritual care is also centered on simply making the patient *feel* valued and needed. This interaction between the cognitive and affective dimensions of spiritual care are nicely encapsulated in the Japanese understanding of the *kokoro*, in which the character for *kokoro*, read *xin* in Chinese, refers to the faculty for both thinking and feeling. This affective dimension of the *kokoro* can be traced to premodern Japan when the character *i* (Ch. *yi*), meaning "intention," was also commonly used for *kokoro*. Based on this history, Thomas Kasulis suggests that the *kokoro* could be defined as a "cognitive form of affective sensitivity."[15] Even 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. English 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. When hospice workers stress the importance of caring for the *kokoro* of patients, one might say that this type of 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 in the face of death may give some patients peace of mind, care for the *kokoro* also includes a wide range of mundane activities and interactions between hospice workers and patients that help the patient constantly *feel* their worth by letting them "be themselves." This in turn communicates to the patient that they are highly valued and that their lives still have meaning—a kind of *kokoro* care that forms the foundation of spiritual care. In other words, while spiritual care is often articulated in terms of supporting a patient's belief system, care for the *kokoro* does not clearly distinguish between supporting patients in their beliefs, their emotional sensibilities, or even their physical needs.

3

The Heart of Practicing Spiritual Care

Spiritual care in Japan is not only based on supporting the *kokoro* of patients through daily care, but also on cultivating the *kokoro* of caregivers themselves in ways that imbue their work with "spiritual" meaning. A veteran Christian doctor explained it this way.

> 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*] 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.[1]

From this doctor's perspective, spiritual care was ultimately a matter of the *kokoro*. It is also a type of care that was more or less intuitive and could be provided by all the hospice staff. Staff members were simply asked to value the patient in their own *kokoro*. Another 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.[2]

As this nurse suggested, spiritual care in practice rarely involved directly addressing a particular religious need or existential crises in patients. Rather, spiritual care began with managing one's own *kokoro* while practicing regular care with the aim of making patients feel comfortable. This idea echoes the predominant view among both chaplains and hospice staff that spiritual care is less about *what* is being done and more about *how* it is conducted. This includes what I have termed vocal care, resonating care, and supportive care. These categories may not be comprehensive (they are certainly not mutually exclusive) but help focus attention on the *way* spiritual care is practiced rather than on the content of the care. In short, these categories examine what spiritual care looks, sounds, and feels like.

CHAPEL SERVICES

The day begins in many hospices with morning assembly (*chōrei*). 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 on religious overtones. At Christian hospices for example, the morning assembly may double as a chapel service led by the chaplain that involves a scripture reading, hymn, or song, followed by a short inspirational story or sermon, and prayer. At one Protestant hospice, a Christian doctor was invited to open the workday by sharing a short Bible story from the Gospel of Luke on how Jesus instructed his disciples to cast their fishing nets over 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's suggestion to the disciples resulted in a catch of fish so heavy that it could not be hauled in, so too, this doctor suggested, should staff remain open to being corrected by others. At another Catholic hospice, there was no scripture reading or prayer, but the morning assembly began with everyone singing a hymn. After singing, each day a different staff member took turns to share a short uplifting story or recent episode from their daily life that could help set a positive tone for the workday. When the morning assembly took the form of a chapel service, patients and families were also encouraged to participate. At one hospice, the chapel service was even broadcast over the public announcement system and made viewable by patients on their TV sets.

At a Buddhist Vihāra ward I visited, the day both began and ended with a short service called *omairi. Omairi* typically refers to visiting a temple, shrine, or an ancestor's grave for purposes of worship, prayer, or paying respect. In the Vihāra ward, this name was repurposed for their chapel service. At the appointed time, staff and patients would enter a small Vihāra hall where they took prayer beads and a small volume of sutra excerpts in hand. Participants followed the Vihāra priest in reciting the "Verses of the Serious Vow" (Jūseige) in the morning and the "Verses of Praises to the Buddha" (Sanbutsuge) in the afternoon while facing the Buddhist altar at the front of the room. At another Vihāra ward, a similar *omairi* service began by chanting the "Threefold Refuge" (Sankiemon) and then the "Heart Sūtra" (Hannya shingyō) while facing a seventeenth-century bodhisattva image from Burma. The foreign provenance of the image was intentional since it stressed the trans-sectarian nature of the hospice.[3] Each recitation took about five minutes. During the afternoon *omairi*, one of the Vihāra priests also delivered a short sermon of about ten minutes that was humorous or inspirational.

At one such service I sat next to a patient 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 originally from a temple family. One night while he and his brother were studying for school exams, they heard a loud noise. Their mother had fallen down the stairs and was bleeding profusely. They immediately called an ambulance; on the way to the hospital they kept asking her if she could remember her name. The only thing she said to her son before she fell unconscious for ten days was to "value the *nenbutsu*" (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 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 or ministers from the local community also helped give chapel messages. On a hot summer day, I joined one patient, two doctors, and three nurses while a local Buddhist priest gave a short talk after the *obon* 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. Perhaps 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 the morning assembly and other services varied widely. When the morning assembly took place before the day shift, staff participation was usually voluntary. In such cases, only a few staff, if any, would participate. At one Christian hospice that suffered from low staff attendance in chapel, the chaplain related how he then began going to the nurses' 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 counted as part of the workday and staff attendance was mandatory except for those who were attending on patients. In reality, however, since many nurses and doctors made checking the status of their patients a priority in the morning, attending assembly was more of an afterthought. For others, listening to the organ while sitting in the chapel or reciting a sutra was seen as an opportunity to collect themselves before rushing into their busy day. Patient attendance also varied. If patients could still walk on their own and were either deeply religious or bored, they might attend. Most often, however, bedridden patients with no strong interest in attending were content to stay in their rooms where they might be still finishing breakfast or dozing. One Vihāra ward recorded that 38% of 187 patients attended at least one *omairi* service between 2008 and 2011.[4] Yet when I visited this hospice in 2012 and 2014, there were rarely more than two or three patients in attendance.

WHERE DOES RELIGION FIT IN?

In general, other than morning assembly or *omairi* type services, religious care for patients plays a minor role in most Japanese hospices. By religious care, I refer to those activities and interactions with patients that are openly framed in the language of particular religious traditions, that include chapel services, prayer, scripture recitation, or open-ended conversation on religious topics between patients and chaplains. In fact, even the *omairi* services in Buddhist hospices were framed as a traditional cultural rite that many nonreligious Japanese might conduct at home in front of their Buddhist altar. Taniyama Yōzō, who formerly served as a Vihāra priest, 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.[5] A popular textbook on spiritual care also explains in its opening that, "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."[6] Likewise, several Christian chaplains I spoke with estimated that approximately 80 to 90% of patients did not or were unable to communicate interest in religious or existential subjects while in the hospice.[7] At another hospice affiliated with a Buddhist new religious group, Risshō Kōseikai, a doctor noted, "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."[8] Ultimately, this hospice chose to discontinue having a full-time chaplain on call.

While many chaplains explained that only a few patients ever outwardly expressed interest in conversing about religion, family members of patients sometimes felt that patients did receive religious care anyway. For example, a survey of 378 bereaved families indicated that nearly a quarter of family members believed that patients received some sort of religious care during their stay in a religious hospice. Of those who felt they did not receive religious care, 44% explained that this was because the patient had a poor image of religion or was not in need of religious care, and 38% explained that this was because their physical condition prevented them from receiving such care. 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.'"[9] The discrepancy between the hospice workers' claim that religious care is rare, and the patient family's view that such care did in fact take place, may be because patient families had a looser conception than chaplains in their understanding of what might constitute religious care.

WHY IS RELIGIOUS CARE SO RARE?

There are several explanations for why hospice chaplains in Japan have few opportunities to provide religious care. First, many patients have only a faint idea of who chaplains are or what their work entails. In some cases, even other 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. To encourage familiarity with their work, many chaplains eschew their official title and the foreign sounding word "chaplain" in favor of more self-explanatory titles such as "counselor" (*kaunselā*), the "hospital priest" (*byōin no obōsan*), or simply "pastor" (*bokushi*). When introducing themselves to patients, chaplains also rarely describe their work as providing spiritual care. Although the term "spiritual care" is used among staff and recorded 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. This included the way I presented my own research to patients as well. Since most patients had no idea what "spiritual care" meant, I explained that I was conducting research on end-of-life care for the *kokoro.*

Even if patients were familiar with spiritual care, however, many patients are simply not in the hospice long enough to receive it. In 2000, for example, 92% of patients stayed in hospice for at least a month; but by 2019 this number had shrunk to 37%. Likewise, the number of patients who stayed for at least two months has declined in the same period from 20% to just 2%.[10] 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.

What this means for hospice workers is that instead of getting to know a patient over a month or two, hospice staff must increasingly acquaint themselves with a patient over a space of weeks. Moreover, since these weeks come at the very 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 communication abilities, there are simply fewer opportunities to have meaningful conversations with patients. 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.

Another reason religious care is rare is because many Japanese remain suspicious of religious professionals. In a 2012 survey conducted by the Japan Hospice Palliative Care Foundation (JHPC), more than half of respondents stated that they 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*.[11] 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 felt toward religious professionals became particularly exacerbated after the new religious group Aum Shinrikyō carried out the sarin gas attack in the Tokyo subway system in 1995. In the aftermath of this attack, new legal restrictions were placed on religious groups and the widely broadcast images of Aum adherents supposedly being brainwashed instilled a deep suspicion of religious groups for many Japanese. Although historically speaking, the public suspicion toward and government crackdowns on certain religious groups was not anything new, the Aum affair represented an important paradigm shift in the public perception of religious groups from that of working for the public good and deserving of tax exemption, to that of potentially dangerous and in need of close supervision.[12] In such a climate, 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*) and patients would respond relatively positively. After the Aum incident, she began describing her work as simply "*kokoro* care" to avoid a negative reaction. This kind of self-censorship resembles what Isaac Gagné labels "reflexive secularization," which is a process by which religious organizations intentionally transform the religious elements of their tradition into forms that are more palatable for a secular audience as a way to continue to attract new members or maintain their position in society.[13]

The cumulative effect of this cultural and historical context is that chaplains only occasionally draw on their religious expertise in their dealings with patients. Instead, their explicitly religious roles are mostly confined to leading morning assembly or other religious services where they lead sutra recitations, sing hymns, pray, or give an inspiring sermon. Instead, chaplains and other hospice workers define the spiritual care they provide to patients as having less to do with religious care and more about approaching patients with a *kokoro* that shows empathy, respect, and concern to help them feel valued at the end of life.

VISITING WITH PATIENTS

When I first met Sister Yamada, who served as a chaplain at a Catholic hospice in Japan's western island of 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*) and those who are backward-looking (*ushiromuki*). 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 gave a peculiar introduction of herself, saying, "I am cancer. Cancer is my friend. We are doing well together." In the Japanese language, it is not uncommon to say, "I am cancer" (*watashi wa gan desu*). This means that a person "has" cancer. When I explained that I was interested in how hospices provided care for the *kokoro* of patients, Uejima-san 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.

UEJIMA: Good.
SISTER YAMADA: You look well today, too.
UEJIMA: Really?
SISTER YAMADA: It sure would be nice if things stayed this way.
UEJIMA: But you never know when things will change.

Sister Yamada pursed her lips and paused, sensing that her last remark might have been insensitive to someone to whom death was imminent. Instead of trying to cover up this indiscrete remark or change the topic, she addressed it head on. "It's not good to say something like that to someone who can't stay the same way, is it?"

"No, I suppose not," Uejima replied.

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 gloomy demeanor. Sister Yamada advised her to try to pursue these positive glimmers and to mine them further when conversing with the patient. This is not to say that Sister Yamada was always trying to cheer up patients.

As a former hospice nurse, Sister Yamada was well aware of the need for empathy and allowing patients to share their honest feelings. But she also emphasized her responsibility to help patients also find things to be thankful for no matter how depressed they might feel.

VOCAL CARE

Many of Sister Yamada's interactions with patients served as a good example of how she practiced vocal care. 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. 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.[14] Vocal care may occasionally include religious care. Chaplains may read, recite, or sing through scripture with the patient or answer questions about guilt, forgiveness, anger, or the afterlife from their own religious perspective. At one Buddhist hospice, a Vihāra priest described a patient who had confessed to him that she had not conducted memorial services for a fetus she had aborted in her youth. Since she strongly felt that her current illness was due to this lapse, the priest hastily arranged for a Buddhist memorial service that gave her great relief before she died.[15]

However, vocal care has become increasingly difficult to practice since many patients are unable to communicate. For example, one patient Sister Yamada visited 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 say, "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 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 expensive looking portrait of the patient's grandson from her bedside table. She asked, "Is this photo from his coming of age ceremony?" The patient gestured no. "Then, perhaps for a marriage interview?" She gestured no again, and her face showed her frustration and disappointment. I sensed the patient was about ready to give up, but 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 Sister Yamada's mouth, the patient's hand shot up to cover 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 still communicate. For example, Takagi-san was in her late seventies, originally from Nagoya, and had returned to her hometown in Kyūshū to die near her sister. Whenever 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 whom I met in a Vihāra ward. He had lung cancer. 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 middle-school annual reunion, which was going to be held at the end of that month. It was doubtful whether he would live that long, but he was fixated on putting all the reunion files in order so he could pass these on to a classmate for subsequent years. He was very punctilious and independent. For instance, he firmly 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, Reverend Sasaki, first chatted with him about his eldest son who had visited the day before and about his two other children. Shitakubo-san was concerned with 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 either. 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, Reverend 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. Reverend 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 returned from an overnight home visit. After chatting about how things went, Reverend Sasaki commented: "Shitakubo-san, you aren't really the type to outwardly express anxiety [*fuan*], are you?" He replied: "I might just be thickheaded . . . I'm an atheist too." After we left his room, Reverend Sasaki seemed thoughtful. "I think that he is feeling spiritual pain somewhere. He calls himself an atheist [*mushinronsha*] but he uses the Buddhist word for 'life and death' [*shōji*] and I saw him reading a book about Shinran.[16] Japanese simply just don't show their religious views up front very much." Reverend Sasaki also added that Shitakubo-san's remark about being an atheist may have been a veiled apology for not being able to talk more frankly about religious topics with the Vihāra priest.

By contrast, when I interviewed a chaplain in the cafeteria of an American hospital, a woman who just happened to walk by our table had no qualms in interrupting our conversation to ask the chaplain, "Are you the chaplain? Could you please go visit and pray with my son?" It was nearly impossible to imagine a similar interaction occurring in a Japanese hospital where religious identity is not typically a subject that comes up in passing. There was even a case where a Japanese patient secretly got baptized before entering the hospice. The family discovered this fact only after his death when they read his journal and found his request for a Christian funeral. The nurse who related this story explained that she felt bad when she heard this, since she would have been happy to connect him with a chaplain or provide other opportunities for religious care if she had known he was religious in the first place.

Both chaplains and other hospice staff are aware that many patients are reticent to share their personal, let alone religious, concerns, if they have any. It takes 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*).[17] This reluctance among Japanese patients to talk candidly with caregivers about their private beliefs or feelings is certainly not unique to the hospice setting. For example, Japanese psychiatrists are also known to emphasize nonverbal approaches with clients by using sandbox, clay sculpture, and especially box garden therapy (*hakoniwa*) to help reticent patients to express their feelings.[18]

RESONATING CARE

The difficulty in practicing vocal care draws attention to another way that spiritual care is practiced: resonating care. Resonating care places an emphasis on simply *being* with the patient. In addition to 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 their own being. Resonating care also claims no overt forms of care techniques other than spending quality time with the patient. As one nurse explained to me, "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."[19]

Another nurse echoed this sentiment while explaining how she provided spiritual care to patients who asked difficult questions:

> 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.[20]

Prayer might also be included as a form of resonating care. Although prayers are said aloud for the benefit of the patient, they are also silently uttered by chaplains at the bedside of unconscious patients and at the privacy of their desk throughout the day. These prayers help sustain the relationship between the caregiver and the patient, allowing the pain of patients to constantly resonate in the chaplain's *kokoro*. As Andō Yasunori, a scholar of Japanese religion, notes, spiritual care is less about what is being done and more about the relationship between the medical worker and the patient:

> 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*] 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.[21]

Andō posits that anything can be labeled spiritual care if it is done in the right spirit. It also stands in contrast with regular medical care, which is largely defined by the content of care. Adjusting a patient's morphine titration or helping a patient take 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. 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 *kokoro* of the caregiver.

SUPPORTIVE CARE

Supportive care refers to creating a hospice environment that helps the patient affirm their value amid 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. 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 an abundance of artwork, hospices make

FIGURE 2. A shade to hide the patient's reflection (Photo by author).

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 could be pulled down over the bathroom mirror so that patients did not have to be reminded of how their body had deteriorated during their stay.

Many hospices also provided patients the option of staying in a tatami-mat room, since many Japanese wish to "die on top of the tatami" (*tatami no ue ni shinitai*), evoking the image of a natural death.[22] 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 other prayer and meditation rooms are made available for patients (and staff) to use.[23] At a Buddhist Vihāra ward in Kyūshū, the entire ward was built with Japanese cypress trimming by carpenters (*miyadaiku*) who specialize in the traditional art of building temples and shrines 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.

Supportive care also includes paying attention to and supporting the patient's favorite activities, arranging for social events, and engaging 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. At a Vihāra ward 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 in the garden. 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. Often, they ate lunch with patients and their families in the common room. Although the Vihāra priests did also visit patients to provide private counsel on matters related to their death, the most striking image of the Vihāra priests during my fieldwork was how they were simply *living with* 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 frightened. It is only because there is 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 that the Vihāra priest provides, hospice care would be a scary ride.[24]

Much of this support is provided in the form of social activities. The hospice is constantly flowing with events and activities for patients. Music therapists come weekly, as do animal therapists, aroma therapists, and even beauticians. Most of these visitors are volunteers or supported by nonprofit organizations. Baristas visit weekly to make coffee; 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.

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 to sing Christmas carols, receive presents, and take pictures with Santa. At a Buddhist hospice, they held a "fun party" (*otanoshimikai*) during the Christmas season instead. In the springtime, patients are wheeled outside for cherry blossom viewings, and during the summer, staff might set up a small festival (*omatsuri*) for patients. At a Buddhist hospice, I helped patients make *ohagi* (soft rice cakes covered with sweetened red bean paste) during the autumn equinox. Patient birthdays were also enthusiastically celebrated. Afterward, pictures from these events were given to patients to pin on their wall or to family members as keepsakes.

Many of these activities were led by chaplains. As one Protestant hospice, a weekly "teatime" took place where patients and families sang songs, listened to a short message given by the chaplain, and spent time getting to know other patients while eating snacks and drinking tea. At another Catholic hospice, the chaplain led a weekly gathering called "*kokoro* time" (*kokoro no jikan*), where patients, families, and volunteers sang traditional Japanese songs and then shared stories on a topic like, "something from this week that made me happy." Vihāra priests were also proactive in arranging activities for patients. When the weather was nice, the priests often wheeled patients out for a nature walk through 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 one patient's veranda.

Special events might also be tailored with certain patients in mind. One patient at a Vihāra ward enjoyed watching films. Upon learning this, the 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 with her popcorn.

One day, Reverend Sasaki showed me a picture of a large 1200cc motorcycle. It had belonged to a middle-aged male patient who loved motorcycles so much that he rode his bike to the hospice and parked it on his 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. Reverend 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*). He jokingly explained, "You might even say that we are doing preventive spiritual care."

Supportive care stresses the importance of supporting the patient's ability to die in a way that reflects who they are (*jibunrashiku shinu*). In this regard, it closely resembles the more general emphasis on *kokoro* care. One nurse explained her view of 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.[25]

As such descriptions suggest, despite the often-repeated mantra in spiritual-care settings 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.[26]

However, although both medical workers and chaplains openly acknowledge that what they call spiritual care in practice is more about supporting the *kokoro* of patients, they hinted of a tension in their work. In short, many chaplains sensed a gap between the idealized models of spiritual care as found in professional hospice literature and what they actually did on a daily basis for hospice patients. During my fieldwork, some chaplains were even 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 in his hospice by noting that many patients 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 his records that this was the "golden age" of their careers in spiritual care. Christian chaplains also tended to recount the rare cases where patients found religious 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

Apart from chapel 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 is typically confined to interacting with a handful of patients who are active members of a faith tradition. However, even though I only rarely observed religious language or sacramental care by chaplains in their dealings with most patients, many chaplains stressed in no uncertain terms that their religious training and beliefs were still 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 was ever a discussion in the early years of the hospice movement about the difference was between providing spiritual care and religious care. 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. In other words, the supportive dimensions of spiritual care resembles "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."[27] As Courtney Bender notes in her study of kitchen volunteers in New York City, in the right context, counting plastic food containers is "as though I'm praying," and "cutting carrots is really a lot like meditating."[28] Likewise, the retired 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 normal activities aimed at supporting patients.

Chaplains also suggest that their work is not just an extension of their devotional life, but that in order to be an effective practitioner of spiritual care, having a robust set of beliefs and values that serve as an existential anchor is necessary in order to respond to the deep questions that patients might occasionally 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*] behind you." This really made sense to me. If I am secure in knowing that God loves and accepts me, I just need to be that way before the patient. This is the basis of spiritual care.[29]

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.[30] 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. It is not simply enough to just value the patient as a person, a type of relational care that some hospice workers describe as "horizontal."[31] Instead, ideally, spiritual care is also "vertical"—a type of care that draws on a religious background or existential security that allows the caregiver to transcend the moment by helping the patient connect with something beyond themselves. This religious background gives the spiritual caregiver buoyancy that allows him or her to assist floundering patients in a sea of suffering.

The perceived importance of having a religious background or training for spiritual caregivers is important since this is also one of the ways chaplains distinguish their work from that of clinical psychologists. Chaplains explain 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 working at a nonreligious hospital in Osaka 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 her psychological training from time to time when she thought a patient might be suffering from depression or mental illness, her approach to work was essentially 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 struggled to distinguish between the differences in psychological and spiritual care.[32]

In this way, chaplains readily admitted that religious care only constituted a very small part of their daily activities, but they also pointed out that their work could not be done by just anyone and that their religious identity remained integral to their work. They saw their role as important precisely because a religious professional could offer something that a clinical psychologist or nurse could not. Chaplains believed that although spiritual pain is often expressed in terms of psychological stress, beneath the surface were deeper philosophical doubts, religious questions, and a desire for relief (*kyūsai*) that chaplains from a religious background were better trained to deal with.[33]

Even as many chaplains privately viewed their work as an extension of their religious commitments or their presence as buoys that patients could grab hold of in a sea of uncertainty before death, the allergy many contemporary Japanese profess toward religion required chaplains to frame their work in the hospice carefully. In order to encourage the vocation of hospital chaplaincy to become mainstream, chaplains must publicly articulate their roles in psychotherapeutic terms since many Japanese—including their medical colleagues—harbor suspicions that they might have a religious agenda. Consequently, even though chaplains stress the importance of their religious training and identity in private, in public they are careful to present their work as "spiritual" and not "religious" in character.

CONCLUSION

Nurses, doctors, volunteers, 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 rally. While these activities might look, sound, and feel different from praying with, counseling, or sitting quietly beside patients in their "search for meaning," they all form the basis of the hospice staff's understanding of spiritual care.[34] Although the spiritual dimension of hospice care is often treated as a distinct from physical or psychological care in theory, spiritual care in practice often collapses these categories. Hospice staff conduct spiritual care in the margins of regular care and understand spiritual care as anything that make patients feel valued and allows them to be themselves. Chaplains or other staff still support or counsel patients when they have religious or existential concerns; but 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. Whereas vocal and resonating care remain the central tenets of professional models of spiritual care that emphasize the need to help patients along in their journey to find "meaning," in practice, 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 term "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 personal 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, since many contemporary Japanese typically express few concerns about religious questions of faith or belief, supportive care plays an important role in fostering an environment where patients feel comfortable and cared for.[35]

Claiming that faith and belief are not as important for patients runs the risk ignoring the experiences of many ardent Buddhist, Christian, or believers of new religions in Japan, but the relative lack of religious care in the Japanese hospice reinforces this point. This is also seen in how chaplains felt a tension between idealized images of spiritual care and what they actually did for patients. While chaplains understood that the companionship they provided patients was important for helping patients feel valued and supported, they also referred to cases of interactions with patients who struggled with existential or religious questions as more representative of "real" spiritual care. 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 more of a supportive manner 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 "religious" cultures, is thus a matter of ongoing debate.

4

The Meaning of Spiritual Pain

Nakano Kōji (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 to decide whether to pursue aggressive treatment in order to prolong his life. As he grew increasingly frail, he also mused on what living meant 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, inkstone, 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 meaning apart from or beyond his daily activities and relationships. This type of self-realization in one's work, hobbies, family, or other relationships is often expressed as a person's *ikigai*.[2] His simple pleasures *were* his life.

If Nakano had entered a hospice, his increasing inability to walk his dogs might have also been diagnosed as a source of spiritual pain. As Cicely Saunders put it,

> 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 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.[3]

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. 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.

This chapter reflects on the extent to which Japanese hospice patients grapple with this "search for meaning" at the end of life. Of course, each hospice patient is different from the next and nobody dies the exact same way. There is no common condition behind spiritual pain, nor is it always clear to caregivers what constitutes spiritual pain. Instead, as one might expect, Japanese hospice patients express a range of anxieties when facing the end of life—some of which is explicitly existential or religious, but for the most part is not. Through personal interviews with hospice patients and chaplains, I introduce a core tension that lies at the heart of the concept of spiritual pain. On the one side, I suggest that for most 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 transcend their condition altogether—a response that accords with the general reluctance of many contemporary Japanese to turn to a particular religious tradition for soteriological guidance in life as well.[4] 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, spiritual pain is like a submarine at sea. Even when you cannot see it, it might be lurking below. This tension can make it difficult for hospice workers to distinguish spiritual pain from more mundane needs. Like Nakano, patients' questions about the meaning of their lives are often embedded in very prosaic concerns. Naturally, 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.

The difficulty in identifying spiritual pain impacted my interviews with patients as well. Few patients, if any, were familiar with the idea of spiritual pain. Even if they were aware of the word "spiritual," they often associated it with ghosts and other paranormal phenomena. As a result, I could not ask patients directly about the kinds of spiritual care they received or spiritual pain they experienced. This was liable to create confusion. Instead, I communicated to patients at the outset of each interview that I was researching how the hospice provided *kokoro* care. Key questions I asked included: "What nonphysical 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 well. Sometimes my questions fell flat. Other times patients immediately grasped what I was interested in. The selections here represent what I believe to be the most lucid and direct patient responses to the key questions I posed.[5]

THE FEAR OF BEING A BURDEN

Hara-san was in his late sixties and dying of liver cancer. When I met him, he had been in the hospice for a little over a week. As I walked toward his room with the head nurse, she mentioned to me that he took great pride in staying busy. He 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.

BENEDICT: So, let's start.

HARA: Ask me anything.

BENEDICT: First, could you explain a little bit about how you came to the hospice?

HARA: Do you need the specific dates or . . .

BENEDICT: No, not at all. Just the gist.

HARA: In the middle of last month, I started to feel unwell.

[*There is a knock at the door. A volunteer brings in an afternoon snack.*]

BENEDICT: So, in the middle of last month . . .

HARA: 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, but it was also 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, 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, 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 the doctor 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 [renovating] the bathroom and bath yet, but I was able to make arrangements. 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.

BENEDICT: Yes, it did rain yesterday.

HARA: During the rainy season, very few people request construction. The reason is because if it is humid when you are painting . . .

BENEDICT: Ah . . . that can't be good.

HARA: 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.*]

BENEDICT: Please, go ahead.

HARA: No, I'll turn it off. Hello? I'm being interviewed right now so I'll call you later . . . yes. [*click.*] Excuse me.

BENEDICT: No, no, not at all.

HARA: And then . . .

BENEDICT: The scaffolding . . .

HARA: The scaffolding costs ten thousand yen a day. 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.*]

BENEDICT: You have been making all kinds of preparations . . .

HARA: I have been most vigorously active! [*Laughter.*]

BENEDICT: You sure have!

HARA: Now . . . what was it I was meaning to say . . . um . . .

BENEDICT: How you got to this point . . .

HARA: 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*] 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.*]

HARA: I don't want to die in a pitiful manner. For example, please excuse me for using the word "pitiable" [*nasakenai*] 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 be able 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*]. 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.

BENEDICT: So, at first you felt that you needed to put things in order . . .

HARA: 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.

BENEDICT: I see, I definitely understand. So, as you went about working on your home, the burden on your *kokoro* gradually lessened.

HARA: Yes, it lessened. I am now comfortable [*raku*].

BENEDICT: So, did you have any other particular kinds of worries [*fuan*] or stress [*sutoresu*]?

HARA: 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! [*More laughter.*]

One of the most commonly held anxieties voiced by hospice patients in Japan is a strong desire to not become a burden (*meiwaku*) on others. As Hara-san explained, his first priority was putting all of his affairs in order before he died. As he accomplished these goals, which he had delayed for so long, the burden on his *kokoro* "became lighter and lighter." It was clear that he derived deep 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 thankful that cancer allowed him to stay independent longer than other incapacitating illnesses. For example, he described his mother, who became bedridden after 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*) instead of in a traditional Buddhist temple plot. 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 new 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.[6] 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.

Hara-san's concern about becoming a burden reflects an idealization of a certain manner of death in Japan. As Susan Orpett Long has demonstrated, two dominant cultural scripts for an ideal death in Japan are *rōsui* (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* (a sudden death), which does not impose the burden of a long hospitalization on the family.[7] Notably, the idealization of these two contrasting types of death stems from the same rationale—a desire to not burden others. Although slightly removed from the hospice context, similar ethnographic work on the lives of the elderly also suggests that the anxiety felt 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.[8]

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.

> DAUGHTER: 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*].
>
> ARITA: Being at home was emotionally difficult . . .
>
> DAUGHTER: I was glad I could show respect to my mother [*oya kōkō*] by helping her and planned to keep doing so, but my mother is sensitive [*ki o tsukau*] [about 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." [*Laughter.*]

Encountering Japanese patients like Hara-san or Arita-san who cite being a burden on their family, friends, and caregivers as one of their strongest concerns at the end of life is not surprising, nor 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" (SPB).[9] What sets Japan apart from other hospice settings, however, is that physicians and nurses in Japan do

TABLE 1. Existential concerns of terminally ill Japanese cancer patients

Acceptance/preparation	25%
Relationship-related concerns Isolation Concerns about family preparation Conflicts in relationship	22%
Hope/hopelessness	17%
Loss of control Physical control (dependency) Cognitive control Control over future (uncertainty)	16%
Loss of continuity Loss of role Loss of enjoyable activity Loss of being oneself	10%
Uncompleted life task	6.8%
Burden on others	4.5%

SOURCE: Morita et al., "Existential Concerns of Terminally Ill Cancer Patients Receiving Specialized Palliative Care in Japan," *Support Care Cancer* 12 (2004): 138.

not hesitate to indicate this self-perceived burden as a type of spiritual pain. Statements from patients like, "I want to die before I become a burden on others," or, "I don't want to cause anxiety and trouble to my husband" are believed to indicate spiritual pain.[10] In a survey by Morita Tatsuya, a veteran hospice physician and leader in Japanese hospice care research, he identifies seven categories for existential pain (*jitsuzonteki itami*), which he treats as synonymous with spiritual pain.

According to Morita, about a quarter of the eighty-eight patients interviewed by his team 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 5% 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 partly due 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 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," which included expressions of concern about their family's preparation for their death. In effect, several of these categories doubled as expressions of concern about becoming a burden to immediate family members.

Classifying a patient's self-perceived burden as a type of spiritual pain stands in contrast to the ways spiritual pain is measured in the United States, where widely used surveys on spiritual well-being like the "Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being 12 Item Scale" (FACIT-Sp-12) contains 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.[11] This is not because American hospice patients do not worry about becoming a burden on others. They certainly do. But these types of concerns are less likely to be labeled as "spiritual" in nature.

Identification of the patient's self-perceived burden as a form of spiritual pain in Japan also raises questions. For example, it is not entirely clear how such anxieties might differ from the concerns that 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 could also be generic expressions of concern by patients who care deeply about their families and simply do not want to be a burden on them. In this way, patient expressions of self-perceived burden cannot escape a fundamental interpretive ambiguity; they can be understood either as natural reactions to becoming dependent on others for end-of-life care, or as signifying a deeper existential insecurity in the face of approaching death. It is also not yet clear whether this concern is particular to hospice-care wards or also applies to patients who die at home. There may in fact be some self-selecting bias present, since there is a high probability that Japanese who are concerned about being a burden on caregivers would prefer to die in a palliative care ward rather than rely on family members to provide end of life care at home.[12] Either way, one possible reason why a fear of being a burden is sometimes considered a form of spiritual pain by Japanese hospice workers is the cultural importance placed on repaying social debts (*on*) and fulfilling obligations (*giri*). An inability to repay such debts could conceivably cause deep anxiety for patients to whom the fulfillment of these obligations helps give their life meaning, thus causing spiritual pain.

IT CANNOT BE HELPED

Many patients I spoke with suggested that the reason existential questions about meaning or purpose, or the afterlife, were less of a concern for them, was because they saw death as inevitable, and that worrying about it would not change anything. Patients described such questions as problems that could not be helped (*shiyō ga nai* or *shikata ga nai*; lit., there is no way [to solve it]). For example, Hara-san, who was busy tying up loose ends, had this to say when I asked him why he did not worry about death.

BENEDICT: Before, you said that you were not afraid of death at all . . .

HARA: Not at all. I've never feared it one bit.

BENEDICT: I see. That is remarkable.

HARA: 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 burden on the family. To think that I can go without this, I thank the gods [*kami ni kansha shiteimasu*]. Cancer is a wonderful disease [*laughs*].

BENEDICT: 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 . . .

HARA: 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*] 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 reiterates that his only real fear was dying in a way that would make him a burden on his family. With vivid memories of his own mother's suffering after her 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 the thought that this would cause him to worry. As he explained, nobody has experienced the afterlife and lived to talk about it, and so there was no point in thinking about it (*kangaetemo shikata ga nai*). 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.

> YANAGI: I've really become amiable [*nagoyaka*], 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.
>
> BENEDICT: You didn't fear death in the past either?
>
> YANAGI: 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.

> BENEDICT: But regarding death . . .
>
> YANAGI: So regarding [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.
>
> BENEDICT: Some patients say that they are fearful of suffering at the end, or of whether there is an afterlife . . .
>
> YANAGI: You just need to make your own story [*monogatari*]. 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*] 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*]. 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*] and after polishing themselves [*migaite*], 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*]. 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 he thought that he might fear death, he no longer had such concerns. In fact, he had his own theory that in the afterlife all humans would be taken to a supernatural realm where they could practice self-cultivation to become 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 the afterlife 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 his 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 come up with his own detailed theory about the afterlife. Yanagi-san had obviously devoted some thought to this issue and was eager to share his theory with both the chaplain and me. This seemed to indicate that while he was convinced that there was no point in worrying about what lay beyond death, this had not stopped him from thinking or wanting to talk about it either.

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.[13] A chaplain at a Christian hospital in Tokyo put it this way.

> In terms of spiritual pain, in my experience, most patients do not have large anxieties [*fuan*]. Instead, they mostly just talk indifferently about themselves [*tan tan to hanasu*]. 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*]. This point is driven home when we occasionally have Korean or Chinese patients. They are much more emotionally involved.[14]

Another chaplain put it more bluntly.

> Japanese are very good at giving up [*akirameru no ga jōzu*]. 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*] but giving up [*akirame*]. 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*].[15]

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*] [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 nonattachment; rather, it is 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.[16]

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 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 period (1926–89) as a particularly stoic generation that survived the political and economic turmoil of the Second World War and its aftermath and then worked tirelessly for their companies and country 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 status quo. In this chaplain's view, these cultural experiences might have helped prepare Japan's wartime and early postwar generation to phlegmatically accept the sufferings that came from dying of cancer.

Notably, while the last chaplain also made a point of distinguishing between the tendency for patients to "give up" difficult questions at the end of life and Buddhist ideas of nonattachment, yet another chaplain suggested to me that the resignation he often saw in patients could stem from Buddhist influence. He shared a story 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*).[17] He noted that this idea of "resignation" (*teikan* or *taikan*) is central to Buddhism in which it means to "see clearly" (Skt. Darśana).[18] In fact, the Japanese word *akirame*, or to "give up," actually stems from this Buddhist sense of the term, "to make clear" (*akiramu*). This helps explain the positive tenor of the claim "Japanese are 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 only rarely prompted outward expressions of deep spiritual anxiety to those who were caring for them. For example, Morita's survey on existential pain, touched on earlier, suggested that the search for meaning was not necessarily the most important "existential" issue for 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 had been meaningful, the meaning of their current condition, or what meaning was left in the remainder of their life, which was assumed by Cicely Saunders to be important components of spiritual pain.[19] On closer examination, however, even these connections prove tenuous. In Morita's survey, expressions of "hope/hopelessness" included patients who looked forward to spending time with their family but worried whether they would live long enough 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."[20] While such statements could signal deep existential fears, they are also quite vague and could refer to any number of nonexistential concerns, such as the fear of physical pain at the end of life, or disappointment over not being able to meet future grandchildren.

Taken together, these results suggest that very few Japanese hospice patients outwardly frame their concerns in 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 imperative to note that there are good indications that death anxiety of this sort 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.[21] In fact, one study of ninety-two terminally ill patients showed them to be less fearful of death than healthy individuals.[22] One explanation for this is that 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?[23]

Studies like these suggest that the infrequency of strong death anxiety among hospice patients is certainly not limited to Japan. While exploring the comparative aspects of death anxiety outside of Japan exceeds the scope of this study, it is worth noting this comparative context to emphasize that Japanese hospice patients are not conditioned by some "samurai-like spirit" that makes them oblivious to the fear of death. Although some chaplains suggested that a cultural stoicism might help explain why patients rarely voice existential or religious concerns, the relative lack of heightened death anxiety in other cultural contexts suggests that other factors are also in play. Rather, my findings simply suggest that studying the minimal degree to which Japanese patients raise existential questions about "meaning" at the end of life may have important cross-cultural implications as well.

On its face, the paucity of Japanese patients who raise questions about meaningfulness undermines traditional definitions of spiritual pain that are centered on what Saunders and others have called "the search for meaning." For many Japanese hospice patients, social and familial concerns often eclipse 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 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, through supportive *kokoro* care that allows the patient to "be themselves" and feel valued by way of special events or even prosaic activities—an affective (rather than cognitive) approach to spiritual care that elicits less resistance from nonreligious patients.

DIGGING FOR SPIRITUAL PAIN

If, seemingly, only a small number of Japanese hospice patients articulate existential or spiritual questions about meaningfulness, guilt, the afterlife, or their relationship with some transcendent power, how necessary are chaplains? Could a clinical psychologist, counselor, or volunteer just as adequately care for patients concerns? More importantly, what does this say about the other side of the core tension in spiritual pain: namely, that spiritual care for patients should not only be available, but is also indispensable for most, if not all, patients, as chaplains, nurses, and doctors strongly insist?

One suggestion proffered by some chaplains to explain the lack of religious or existential forms of spiritual pain is that sometimes you must "dig" for it. In other words, although patients may not be fully conscious of their inner anxieties, they may still have them anyway.[24] To take the case of Yanagi-san, who claimed that he was not afraid of death at all, it was certainly possible that he was experiencing some sort of spiritual pain at a subconscious level—a form of spiritual pain that did not manifest itself through observable symptoms. As a matter of fact, even though Yanagi-san claimed that he did not "fear death," he was also strangely insistent that patients should create their own narrative about the afterlife to achieve peace of mind. Yet, if Yanagi-san himself claimed to be unconcerned about death, on what basis could he be diagnosed as suffering from spiritual pain? Even if he had privately nursed such concerns at one time, if he had successfully coped and come to peace with these concerns in his own way, on what evidence could a hospice worker claim that such a patient was still in need of spiritual care? This is a crucial point that gets to the core tension in the study of spiritual pain. From a medical perspective, without observable symptoms, it is hard to make a case for spiritual pain. At the same time, spiritual pain is not something that can be easily measured, like checking for a fever with a thermometer.

Most of the chaplains I spoke with in Japan believed that whether hospice patients expressed it outwardly or not, the majority experienced some degree of spiritual 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 a facade and that in many cases, caregivers 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 cannot be helped." As one chaplain explained to me, sometimes you must 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 must look for it; patients won't bring it to you. You must 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 holding back [*enryo*].[25] 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.[26]

As this chaplain explained, it was common for patients to conceal their fears. This meant that chaplains could not simply assume that an outwardly placid patient may not be working through some difficult questions. However, although this particular chaplain insisted that patients sometimes 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.

> 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 patient was anxious about dying, but after inheriting a large amount of money, all of a sudden, he or she stops

> worrying! [*Laughter*.] [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 his grandson's team made it to the finals, he really wanted to go watch the game in person. 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, he said he would just have to 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 [disappointment] 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 this 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 stifle 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.[27] 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. At 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. Instead, he credited his stoic reaction to his personal religious faith, which kept his *kokoro* from being disturbed.

In rare cases, an overzealous staff member could actually worsen the patient's condition by trying to probe too aggressively for spiritual pain. For example, a palliative care nurse who worked at a large hospital near Tokyo shared the following story with me.

> 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.[28]

This disturbing anecdote demonstrates the care and sensitivity required of chaplains and other hospice staff who are involved in spiritual care. For example, 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 differences 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.[29]

Even still, many chaplains insist that this 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*]. However, he respected 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*]; 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.[30] 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 it was pointless to dwell 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 hinted 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 real fear. One chaplain also suggested to me that part of the reason that patients are reluctant to talk about spiritual pain was because they feel that posing difficult questions that have no easy answers would actually make them a burden on those who are listening. It was already deeply upsetting for patients to allow others to change or bathe them. To broach larger religious or existential questions to a chaplain or nurse could potentially add to their fear that they were becoming a burden.

MAKING SENSE OF SPIRITUAL PAIN

This apparent contradiction between the low number of Japanese hospice patients who openly raise “spiritual” questions 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. For instance, the belief that every patient has some sort of spiritual pain offers an important way for chaplains to find value in their work and legitimize 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 what Wendy Cadge calls a “strategically vague frame,” that brings a broad range of patient concerns under the purview of spiritual care.[31] 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, without the legitimization that the medical profession confers on their work, religious chaplains would be without a job.

On the other hand, a more charitable interpretation would be that the intuitions of chaplains are sometimes correct—that spiritual pain could be manifested or lie latent in ways that cursory clinical observation will miss. As one chaplain suggested, sometimes you need to “dig” for spiritual pain. 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 the words and behavior of patients. In the eyes of chaplains who are committed to the practice of spiritual care, spiritual pain in the Japanese hospice represents a very amorphous dimension of the patient’s dying experience that eludes the clinical gaze. This is also why chaplains sometimes flag the broader relational concerns patients have about being a burden on their families as marking the presence of a hidden form of spiritual pain. Because the term “spiritual” functions in Japanese hospice care as a floating signifier, it is 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 or deep existential concerns that patients may express. Although patients would never put their own experiences in these terms, caregivers fall back on the label of spiritual pain 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 is not something that patients will naturally bring up with their doctor, like back pain, but is something that is often latent, subconscious, or even repressed. Since there is no single universal “sign” of spiritual pain, “sign-ification” is difficult. Instead, the symptom of spiritual pain first appears by way of entering those words into the patient’s medical chart.

"HOLDING ON TO SOMETHING"

Although the majority of dying patients are not preoccupied with religious questions 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 feel that true spiritual care needs to be "vertical," connecting the patient to something transcendent, as well as "horizontal," which connects patients to those around them.[32] 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:

BENEDICT: 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 . . .

HARA: I understand.

BENEDICT: Yes, they seek something to hold on to. How about you? Do you have something?

HARA: 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 [*nanika 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 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! [*Laughter*.] This was more important!

Hara-san's view was similar to those expressed by Higashimoto-san, another patient who identified himself as nonreligious. 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, Higashimoto-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:

HIGASHIMOTO: Not particularly. However, when you reach this point, I think you begin wanting to hold onto something [*sugaritai mono ga dete kuru*]. 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*]. If I had to say something, I might say this is religious . . . the way everyone is being sensitive to my condition.

BENEDICT: You don't have any particular religion?

HIGASHIMOTO: No, I think I'm a typical [nonreligious] 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.

As Higashimoto-san explained, it was certainly possible that he might find himself supported by religious beliefs, 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 cultural expressions of concern. Like many Japanese, he was vaguely aware of what branch of Buddhism his family was affiliated with, but nothing more. He felt good. Unbeknownst to either of us at the time, he would pass away the next day.

In terms of religious identity, we could say that both Hara-san and Higashimoto-san displayed a kind of "cultural secularism," a form of 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."[33] For instance, Hara-san had made 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 mostly viewed them as symbols of friendly concern for his condition.

Yokoyama-san: "I like to chant when I go into the MRI machine"

For some patients, 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 anticancer treatments had taken their toll. Upon entering her room, I noticed her head was covered with a 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*, a saying by the Chinese Zen master Yunmen (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 (Skt. Ācālā) to be her guardian deity (*mamori kami*). She admitted that while others typically look to Amida Buddha or other heavenly personages for protection, she personally preferred 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.

Ogawa-san: "I decided to go to the place of Jesus"

An even more striking example of a patient who began to hold on to religion at the end of life was Ogawa-san. She 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 very afternoon. She showed me the small cross she was wearing around her neck that she had purchased the day before in honor of this occasion. She had received special permission from her doctor to take a trip to a store to purchase this special symbol. 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.

OGAWA: I was okay with god(s) [*kami-sama*], I was okay with Buddha [*hotoke-sama*], and I was okay with Christ [*kirisuto-sama*]. 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.

BENEDICT: Were you not particularly religious before?

OGAWA: 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."

BENEDICT: But you didn't have any aversion to Buddhism or Christianity in the past?

OGAWA: 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?[34]

BENEDICT: You are very Japanese . . .

OGAWA: Aren't I! Those who don't hold any faith might actually have the most peace. They don't have disputes like religious wars.

BENEDICT: Did you decide to become a Christian after you got sick?

OGAWA: My son works here. He helped me get to know the doctors and chaplains; I tend to fall into these things.

BENEDICT: What made you decide to get baptized? Was it through talking with the chaplains? Or was it by your own request?

OGAWA: 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.

BENEDICT: Did you have anxiety [*fuan*] before this?

OGAWA: No, I didn't. I never really got depressed. It was more like "Oh, well" [in regard to my illness] [*na'chatta mitaina*].

BENEDICT: But you were anxious about where you would go after you died?

OGAWA: 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 then talked a little bit about her family. She had encouraged her son to also become a Christian, but he politely declined. He told her he wasn't that type.

BENEDICT: What do you talk about with the chaplain?

OGAWA: 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 she entered the hospice, she was a "typical Japanese" who occasionally participated in various forms of Buddhist, Shinto, and even Christian religious practices and ceremonies but without any strong sense of a single 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 and the six paths of rebirth. At the end of her notes she wrote:

> The world is eternally nonexistent [*mu*] 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 nonexistent 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 "nonexistence" (*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. Even though her knowledge of Christianity was limited to the scene of Christ carrying the cross in the 1959 classic film *Ben-Hur*, she was committed to being baptized and even tried to urge her son to become a Christian as well.

Mizuno-san: "I am happy with the now"

Mizuno-san was another patient who drew support from religious belief at the end of life—in his case, from Catholicism. He was in his mid-forties and in the very last stage of his battle with esophageal cancer. I met him at a Catholic hospice in Kyūshū where I spoke with him over two weeks of fieldwork 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 to have intensified after entering the hospice. Whenever the 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 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. He particularly liked to criticize how Japanese society only valued men with successful careers. In his youth, he had dreamed of becoming 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 due to his illness, he was forced to start living on social welfare. While receiving psychiatric treatment for his illness, 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 illness 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 replied, "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 Christian faith helped him deal with the disappointment of dying 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 any 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 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 frequent topic of discussion amongst hospice staff. Shortly after I was introduced to Mizuno-san, his doctor came to speak with the chaplain. The chaplain personally 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 underwent a deathbed baptism, or like Mizuno-san, who drew on a religious tradition for support, are relatively 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.[35]

The chaplain added that although most patients (she estimated 80%) 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 represented opportunities for chaplains to draw on their own religious training and identity in providing care.

Of course, descriptions of "shallow" and "deep" forms of spiritual care are loaded terms. From this Christian chaplain's perspective, any kind of care that fell short of helping the patient experience God's eternal love and reassurance in the face of death was necessarily "shallow" and temporary in its effects. This positive portrayal of patients who sought to "hold on to something" provided an important justification for the work of chaplains in the hospice. While such patients may be few and far between, when a hospice patient expresses an interest in something that will help them transcend their anxieties in the face of death, the presence of a religious professional who is trained to speak on such matters can be a welcome presence, both to the patient and other hospice staff who may feel unprepared to care for such patients. These patients not only serve to legitimize hospital 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 in the cases they recounted had found something larger 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 dying patients may either be repressing or otherwise lack the courage to bring spiritual anxieties into the open.

CONCLUSION

Clinical conceptions of spiritual pain in Japan are marked by a tension between the seeming lack of religious and existential anxiety voiced by dying patients and the insistence by chaplains and other hospice staff that all patients still feel some kind of spiritual pain to some degree. From a cynical perspective, 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 may sometimes be manifested in subtle or deeper ways that elide clinical diagnosis. One Buddhist chaplain, for example, was very self-conscious of how his work was often portrayed with a clinical gaze 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*] 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 where you turn it into "something," I feel like it is becoming trivialized.[36]

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 widely 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 actual concerns voiced by patients is significant for several reasons. First, we must recall that most Japanese patients have no idea what the term "spiritual pain" really means, or why the chaplain is even there. Thus, from the patient's perspective, spiritual pain remains an empty or amorphous concept. Second, most Japanese hospice patients describe themselves as not religious and only rarely raise questions about a search for religious 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, many more either appear unconcerned, or, at least, tend to deflect such 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, even when a chaplain has reason to believe a patient has spiritual pain, it can be difficult to address it directly. Instead, spiritual caregivers attempt to support 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" until the end.

None of these findings are to deny the utility of spiritual pain as a valuable tool in clinical settings. The challenges that Japanese chaplains face in legitimizing their profession or even just 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 on to" give chaplains and other proponents of spiritual care reason to believe that there are patients who have deep existential needs that fall outside the purview of clinical psychology. In the meantime, as shown in previous chapters, chaplains and other hospice 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 by noticing that, ultimately, the deepest concerns of hospice patients are entangled in a dynamic bricolage of daily routines, social relationships, psychological pressures—and in some cases, religious beliefs—that are inextricable from what we normally just call life.

5

The Invention of Japanese Spirituality

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. However, I was not there to soak in the sulfuric baths. Instead, I joined more than three thousand participants in the annual conference of the Japanese Association for Clinical Research on Death and Dying. The attendees were current or aspiring hospice workers and included doctors, nurses, social workers, chaplains, scholars, students, and volunteers. As I surveyed the crowds of name-tagged professionals milling around the conference halls, something struck me: end of life care in Japan had become an industry in its own right.

I assumed that the conference would mostly feature presentations by doctors on topics like the benefits of fentanyl over morphine. However, as I perused the thick conference book, I was pleasantly surprised to see a number of presentations on the subject of spiritual care. One talk in particular caught my attention. The presenter was Yamazaki Fumio, the well-known palliative care physician and author of the bestselling book *Dying in a Japanese Hospital* (1990)—the book that helped inspire the Japanese hospice movement by highlighting the poor quality of care for the dying in Japanese 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 his 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?[1]

As the press of hospice workers around me attested, it was a vexing question. The reason it was so vexing is because the question of how to define spirituality in Japan is deeply imbricated in the clinical practice of spiritual care. The doctors, nurses, chaplains, and other hospice workers pressing in around me wanted some answers. What is the relationship between spirituality and religion? How is spiritual care different than psychological care? Do all patients have a "spiritual" dimension that needs care? What makes spiritual care "spiritual"?

In this chapter, I focus on the background and definition of the operative concept in practice of spiritual care—the patient's "spirituality"—and the struggle to define this term by hospice practitioners and scholars. Ultimately, I argue that controversy over how to define the English loan word "spirituality" in Japan 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 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 in Japan are being produced and debated. In short, understandings of spirituality for Japanese society more broadly are being "invented" in the Japanese hospice.[2]

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 (1870–1966)—better known to his English readers as D. T. Suzuki. Suzuki's 1944 work, *Japanese Spirituality* (Nihonteki reisei), showcases his understanding of Japanese spirituality through a sweeping look at Japan's religious history.[3] This work was followed by three additional works that dealt with the same topic: *The Building of Spiritual Japan* (Reisei-teki Nihon no kensetsu; 1946); *The Awakening of Spiritual Japan* (Nihonteki reisei-teki jikaku; 1946); and *The Spiritualization of Japan* (Nihon no reisei-ka; 1947). Although Suzuki wrote privately 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 avoided using the word "religion" (*shūkyō*). Instead, his use of *reisei* represented an early attempt to promote a "nonreligious religion" in Japan; that is, he aimed to reinterpret traditional religious practices and narrow-minded authoritarian institutions in favor of a "true religion" that was freer and more open-minded.[4]

In his first book on the subject, Suzuki begins by acknowledging that the word *reisei* or "spirituality" may not be as familiar to his modern readers as the more common word *seishin* or "mind and spirit." In order to clear up their differences, he first defines *seishin* as that which pertains to the *kokoro* (mind/heart), *tamashii* (spirit/soul), or *chūkaku* (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."[5] 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.*[6]

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.*[7]

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*]—well, we could also call it a *kokoro*—exists. This can be divided into two parts; I will call one "intellect" [*chisei*] and the other "spiritual" [*reisei*]. In Buddhism, I think it is safe to say that the intellect corresponds to the combination of consciousness (Skt. [*mano-*]*vijñāna*) [*ishiki*] and the "seventh consciousness" (Skt. *manas*) [*manashiki*] and the spiritual corresponds to *hannya* (Skt. *prajñā*). However, when you say *hannya*, it is translated as "wisdom" [*chie*], 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*] and its essence is not intellectual.[8]

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. He also presents it as the nonintellectual side of the *kokoro*. In Yogācāra Buddhism, *mano-vijñāna* and *manas* represent the sixth and seventh of eight types of consciousness, while *prajñā*, meaning wisdom, refers to the Buddha's 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 *manas*. 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. Incidentally, Suzuki discounts Shinto as being too intellectual and lacking the spiritual intuition found in Buddhism.[9] Furthermore, although he speaks of a Japanese *reisei*, he suggests that it is also universal, although manifested differently across cultures.

Ultimately, Suzuki saw *reisei* as a fresh term that avoided the baggage that came with the Japanese "shallow" understanding of religion. But the spirituality that Suzuki described was not one that was directly opposed to religion; rather, it was deeper than religion. Although Suzuki allowed that spirituality might be manifested differently around the world, in the case of Japan, he stated that the fundamental insights of Buddhism were the true manifestations of Japanese spirituality. Even though he suggested that spirituality was not an exact synonym with religious consciousness, he believed that they were very much linked. Suzuki also viewed spirituality as something that resided within a person, which becomes "awakened" (*kakusei*) and has an "operation" (*hataraki*) that leads to Buddhist insight. For Suzuki, *reisei* was an integral part of human nature, or even a human faculty. Although he framed it within 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 "awakened."[10]

The significance of Suzuki's introduction of the term *reisei* in Japan went 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, a former Japanese hospital chaplain I interviewed related how Suzuki's work also had a direct 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 like Eric Fromm and Carl Jung—both of whom had close relationships with Suzuki and were influenced by his work.[11] For example, ideas about helping patients with "self-realization" were reminiscent of the Zen Buddhist emphasis on "awakening the true self." This chaplain was now in the peculiar situation where he taught 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 concepts that undergird spiritual care in Japan have from the very beginning been a global conversation where ideas and practices related to spirituality have moved back and forth across cultural borders.[12] In fact, the global context for the invention of spirituality in Japan can be traced back even further to Suzuki's participation in the 1893 World Parliament of Religions where Asian speakers like Swami Vivekananda (1863–1902) helped set forward a universalist vision for religious cooperation in which a "spiritual East" could help counter the materialism of the West. This vision was then further elaborated at the 1936 World Congress of Faiths in London where Suzuki gave a speech on "The Supreme Spiritual Ideal."[13]

THE "SPIRITUAL WORLD" MOVEMENT

For several decades after Suzuki, however the term *reisei* attracted little attention in Japan.[14] This finally changed when the "spiritual world" (*seishin sekai*) or "new spirituality movement" (*shin reisei undo*) began to unfold in the 1970s and '80s and when Japanese bookstores began offering a section called the "spiritual world."[15] This new genre of books was similar to what has been described as New Age literature in the West, and included books on the themes of alterations of mind and spirit, search for the self, self-realization, self-transcendence, and self-liberation.[16] 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 participation in organized religious activities. Religious scholars like Shimazono Susumu have suggested that interest in spirituality represented a third path for many members of Japan's younger generations who sought alternatives to religious ideologies and modern rationalism.[17] While the individualist tendencies of the "spiritual world" were certainly pronounced, it would be incorrect, however, to suggest that these took place only outside of organized religious activities and groups. For example, Agonshū, a new religious group founded in the 1950s by Kiriyama Seiyū (1921–2016), also drew heavily on the concept of "spiritual" to frame their beliefs and teachings, going so far as to claim that Kiriyama was one of the first to start using this term.[18]

In the late 1980s the term *supirichuaru*, a transliteration of the English word "spiritual," rather than *reisei*, began to attract concentrated attention. In English, "spiritual" is closely tied to its root, "spirit." But in Japanese, *supirichuaru* could be freed from the supernatural associations of *reisei*.[19] The eventual eclipse of *reisei* by *supirichuaru* became even more pronounced in the wake of the public backlash against religious groups after the Aum incident in 1995. As a result, authors in the genre of spiritual world literature emphasized less threatening practices such as achieving personal well-being through mindfulness.[20] 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.[21]

This strategy can be observed in the works of Ehara Hiroyuki (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 "spirit" (*rei*) in their titles.[22] But starting in 2001, Ehara vaulted into the publishing stratosphere by writing more than forty books whose titles all contained the word "spiritual" (*supirichuaru*). Ehara himself emphasized the distinction between the paranormal and spiritual by describing the content of his books as "spiritual" and not "spiritualism" (*supirichuarisumu*), since the latter term had been used since the early twentieth century by occult groups as well as by Japanese new religions.[23] To make this point even clearer, Ehara employed a healthy-sounding metaphor: "spiritualism" is like rice, while "spiritual" is like rice porridge and can be more easily digested by beginners.[24]

This healthy metaphor was no accident. Although the word "spiritual" 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.[25] This represented a shift of interest from spirituality as a means of self-actualization to an interest in spirituality as the basis for therapy during and after trauma.[26] However, this so-called spiritual boom that Shimazono and other religious scholars have documented requires some qualification since it 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 not at all familiar with the meaning of *supirichuariti*. In a 2006 survey, for instance, only slightly more than 20% of Japanese were familiar with the term. Recognition improved among college students of whom 45% recognized the term. In the health profession, recognition improved to almost 55% of regular nurses and 85% of palliative care nurses.[27] These numbers suggest that despite growing media coverage of this topic, it remained very much an insider term in medical circles and especially among hospice workers who were introduced to it through their 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. Discussions of spirituality in Japan remained tightly intertwined with the hospice movement—primarily due to the theorization of spiritual pain as a symptom that patients exhibit at the end of life.

SPIRITUALITY IN THE CLINIC

The conversation begun by Suzuki that suggested spirituality as something positive, which is "deeper" and "healthier" than religion, intensified in clinical settings. Eventually, spirituality in clinical settings came to be defined and universalized in global medical literature as a dimension of *being*.[28] Despite 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, questions over the utility of the term "spiritual" to describe the needs of patients often fall to the wayside. Whereas scholars are attentive to the way the concept of spirituality serves to draw boundaries between the secular and religious, in clinical settings, spirituality is mostly treated as a *real* ontological thing. This also allows hospice workers to legitimize their own professional roles as caregivers and healers. 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."[29] In biomedical parlance, patient spirituality can determine health outcomes such as mortality, coping, and recovery.[30] In the United States, where the value of spiritual care is mostly 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.[31] But why did attention to the patient's spirituality become such an important component of end of life care in the first place?

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, the mother of modern hospice care. When Saunders founded the first modern hospice in Britain in the 1960s, she described the patient's "total pain" as having physical, emotional, social, and spiritual components.[32] 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."[33] For Saunders, spiritual pain was most often experienced as meaninglessness. Saunders cites Viktor Frankl's book, *Man's Search for Meaning* (1946), which argued that the primary concern of mankind is a search for meaning, and that "meaning" is what gives us the will to live.[34] 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 toward something greater than themselves, a truth to which they can be committed."[35] In Saunders's case, the search for "something greater" was informed by her belief that ultimately it was through faith in the Christian 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."[36]

One often-overlooked aspect of Saunders's understanding of total pain is 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 her 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."[37]

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.[38]

Here, Saunders articulated a view of spiritual pain as an "artificial division" that belied the "complex" of total pain. Spiritual pain was simply one way to emphasize the *total* complexity of pain experienced by a person. Nevertheless, as Saunders's 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) eventually became a fundamental tenet of hospice care—including in the World Health Organization's definition of health.

THE WHO'S DEFINITION OF THE "SPIRITUAL"

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."[39]

Here, the WHO followed 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.[40] 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 definition of health in the preamble of the WHO's constitution suggested the inclusion of the word "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, "Health is a dynamic state of complete physical, mental, *spiritual* and social well-being and not merely the absence of disease or infirmity."[41] The proposed addition of the word "spiritual" to the definition of health was reported with great interest in Japan.[42] Although the proposal was ultimately shelved for future study, subsequent studies of spiritual care in Japan often cite this proposed revision as evidence that the rest of the world already recognizes spiritual care as an indispensable component of medical care.[43]

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.[44]

It is noteworthy that the WHO suggested that the spiritual dimension was not necessarily reducible to a category that paralleled 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" that is more than just the sum of all the dimensions. In short, for the WHO, the "spiritual" did not necessarily refer to some individuated dimension of personhood per se, but was equivalent to the existential self. Accordingly, spiritual pain was often discussed in the context of searching for meaning and purpose, which concern reasons for individual existence.[45] 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 AND LEGALIZATION OF SPIRITUALITY

Although global recognition of the concept of spiritual pain was welcomed by clinicians who were concerned about the overmedicalized aspects of end-of-life care, some spiritual care 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's leadership, and its ethos in the mid-1990s, to argue that "the 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."[46] The 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."[47]

Bishop argued that Saunders's 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."[48] In order for chaplains to prevent themselves from being both institutionally and ideologically marginalized in their work, they were required to strike an awkward balance between embracing and distancing themselves from the language of medicine and religion as they presented themselves to patients and colleagues.[49] This suggests how framing their work as "spiritual" also allowed chaplains to maintain or contest the acceptable parameters of religious care for patients in medicalized settings that were focused on assessment of patient outcomes.

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

> On the other hand, there is something slightly imperialist about a concept like "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.[50]

As these authors pointed out, for all its good intentions, the integration of spiritual care within hospice care was not immune to the clinical gaze.

The medicalization of spiritual care in ways that turned "holding the hand of a patient" into a technology of care that could be clinically quantified and assessed, took the chaplain, a medical outsider, and made him or her a medical insider. But in doing so, the role and responsibilities of the chaplain had to be defined in relation with the duties of other members of the medical team. This sometimes created confusion about the chaplain's role when duties overlapped. For instance, the work of the chaplain was closely related to the work of clinical psychologists who provide patients with psychological care.[51] Since Saunders herself drew on Frankl's humanistic psychology, it was not always clear how spiritual care differed from Frankl's brand of psychotherapy.[52] Saunders cited Frankl's logotherapy and his emphasis on "man's search for meaning" as key to understanding spiritual pain. But Saunders glossed over the fact that Frankl himself did not use the word "spiritual," but spoke of *existential* frustration or distress.[53] Thus Saunders's appropriation of Frankl indicated that spirituality in the hospice represented not only a relabeling of religion but of humanistic psychology as well.[54] Or, to put it another way, if the well-known psychologist of dying, Elizabeth Kübler-Ross, were alive today, she would likely "be doing spirituality, not psychology."[55]

The application of spirituality in global health care settings has also been influenced by legal concerns. For instance, in her 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 Veterans Affairs 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."[56] This is not to say that the religious aspects of spiritual care were completely removed. In fact, Wendy Cadge has shown that medical workers in American hospitals today still openly employ religious language and frames of reference in their care for patients. However, because chaplains tend to be more cognizant of their precarious position as religious professionals in medical institutions, at times they may actually be *less* likely to openly engage in religious conversations with patients than are other medical staff with a religious background.[57]

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, at least in the American context, are more semantic than substantive. For example, one clinical study goes so far as to suggest that the inclusive public language of spirituality has "contaminated" research on those outcomes of spiritual care that are actually grounded in religious involvement.[58] In short, many clinicians acknowledge that at its heart, "spirituality" often serves as a nonthreatening 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.[59]

JAPANESE APPROPRIATIONS OF SPIRITUALITY IN HOSPICE CARE

As hospice pioneers in Japan promoted Saunders's holistic ideals, the concept of spiritual pain proved remarkably difficult to translate and localize into the Japanese context. In many parts of the world, pastoral care in hospital settings was a relatively familiar sight. But in Japan, the notion that religious professionals could and should be part of a medical team was unprecedented. Furthermore, it was difficult to see what spiritual pain and spiritual care might actually look like in a society with relatively low indicators of religiosity. 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.

One question raised by hospice leaders trying to integrate spiritual care into Japanese clinical settings was the question of where to locate the "spiritual" in patients. The answer to this question had important implications for the practice of spiritual care. Namely, one of the ways spiritual care was legitimized was by portraying spirituality as a *dimension of being*. By showing that there was a locus for spiritual pain, hospice workers were able argue for the importance of spiritual care in clinical terms. The focus of spiritual care was the patient's "spirituality," just as medical care was focused on the patient's body, psychological care was focused on the patient's mind, and social work was focused on the patient's social circumstances.

Another question that arose concerned the relationship between "spiritual" and "religion." Since the public's wary image of religion in Japan complicated a definition of spirituality that was too closely associated with religion, Japanese hospice workers carefully drew lines between religion and spirituality in their models of spiritual care, some arguing that they were mostly separate, and others arguing that they were mostly inseparable. While it is reasonable to assume that attempts to localize spirituality as a dimension of being and outline its relationship with religion would be articulated very differently by hospice workers based on their religious affiliation, 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 questions were also trans-denominational.

LOCATING SPIRITUAL PAIN IN JAPAN

The first step for hospice workers trying to localize the concept of spirituality for 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 different 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 Foucault reminds us, the clinical gaze is inherently ocular.[60] In the end, these efforts to delineate a spiritual dimension in patients, which could serve as the locus of spiritual pain, at times undermined the original tenet of hospice care, which was to treat patients as a *whole* person.

Kashiwagi Tetsuo: The Locus for Spiritual Pain

As one of the leaders of Japan's hospice movement, Kashiwagi Tetsuo was one of 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 began by introducing a hospice patient who struggled to grasp the meaning behind her suffering. Kashiwagi then described the pain the patient felt as the pain of her "spirit/soul" (*tamashii*) and explained how this type of suffering was commonly dealt with through spiritual care (*reiteki kea*) or even religious care (*shūkyōteki kea*). He then repeated Saunders's explanation of total pain and translated spiritual pain as *reiteki* pain with the English term "spiritual" next to it in parentheses. However, Kashiwagi remained slightly uncomfortable with this translation. He later explains:

> 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*] 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.[61]

Here Kashiwagi resorted to using the word *tamashii*, meaning spirit or soul, 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 that was used throughout the Japanese Bible, including over one hundred times in the Psalms alone.[62] Kashiwagi then went on to classify spiritual pain into seven different types.

1. Questioning the meaning of life (*jinsei no imi e no toi*)
2. Changes in one's value system (*kachitaikei no henka*)
3. The meaning of suffering (*kurushimi no imi*)
4. Consciousness of guilt (*tsumi no ishiki*)
5. Fear of death (*shi no kyōfu*)
6. Seeking whether God exists (*kami no sonzai e no tsuikyū*)
7. Worries about one's views on life and death (*shiseikan ni taisuru nayami*)[63]

As this list shows, Kashiwagi's definition of spiritual pain closely followed Saunders's emphasis on a 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 religion 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 stated that while relief (*anshin*) for patients may come from horizontal (*yoko*) relationships, ultimately, peace (*heian*) only came from a vertical (*tate*) relationship with a higher power.[64] He also noted that in addition to staying, listening, being honest, open, flexible, and accepting of the patient, "witnessing" (*risshō*) could also play a part in care for the *tamashii*.[65]

Kashiwagi's choice to translate spiritual pain as "pain of the *tamashii*" also introduced a slight but significant shift in nuance from Saunders's 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 object of pain. It was natural for Kashiwagi to see the *tamashii* as the locus of pain since he believed that humans were made up of a body (*karada*), heart/mind (*kokoro*), and spirit (*tamashii*).[66] 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*)."[67]

As it turned out, however, Kashiwagi's preference for the word *tamashii* would eventually be abandoned. Instead, hospice workers ultimately adopted the practice of leaving the term "spiritual pain" untranslated and simply transliterated it into *katakana* syllabary as *supirichuaru pein*.[68] The decision by hospice workers after Kashiwagi 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, up-to-date, or Westernized. In addition, they can also serve as a euphemism for a native Japanese word that has negative connotations.[69] In the case of "spirituality," all these functions are at play. By employing an English loanword, hospice workers signaled that this concept originated in and reflected the most up-to-date modern 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 have stronger associations with religion or the paranormal. Kashiwagi himself later adopted this convention of referring to "spirituality" as the object of spiritual care.[70] Ultimately, although Kashiwagi did not set forward a detailed vision of what spiritual care entailed, 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 meant for Japanese patients.

Waldemar Kippes: The Spiritual Core of Personhood

One such chaplain was Waldemar Kippes, a German Catholic missionary who founded Japan's earliest spiritual care training program. In 1999, he published a book in Japanese, *Spiritual 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.[71] After acknowledging that Cicely Saunders and the WHO had identified at least four dimensions of personhood, Kippes provided his own schematic diagram that included six dimensions (see figure 3).

Like Kashiwagi, Kippes explained that at the core of every person lay a soul (*tamashii*), which represented the eternal self of personhood, as well as a spirit (*rei*), which represented the "breath" (*iki*) or "life" (*inochi*) that animated all the other dimensions. Surrounding the soul and spirit lay the *kokoro*, which in his view represented one's moral conscience and volition. Beyond the *kokoro* lay the psychological realm (*shinri*), which represented the emotional dimension of a person including the instinctive, unconscious, and subconscious. Kippes also

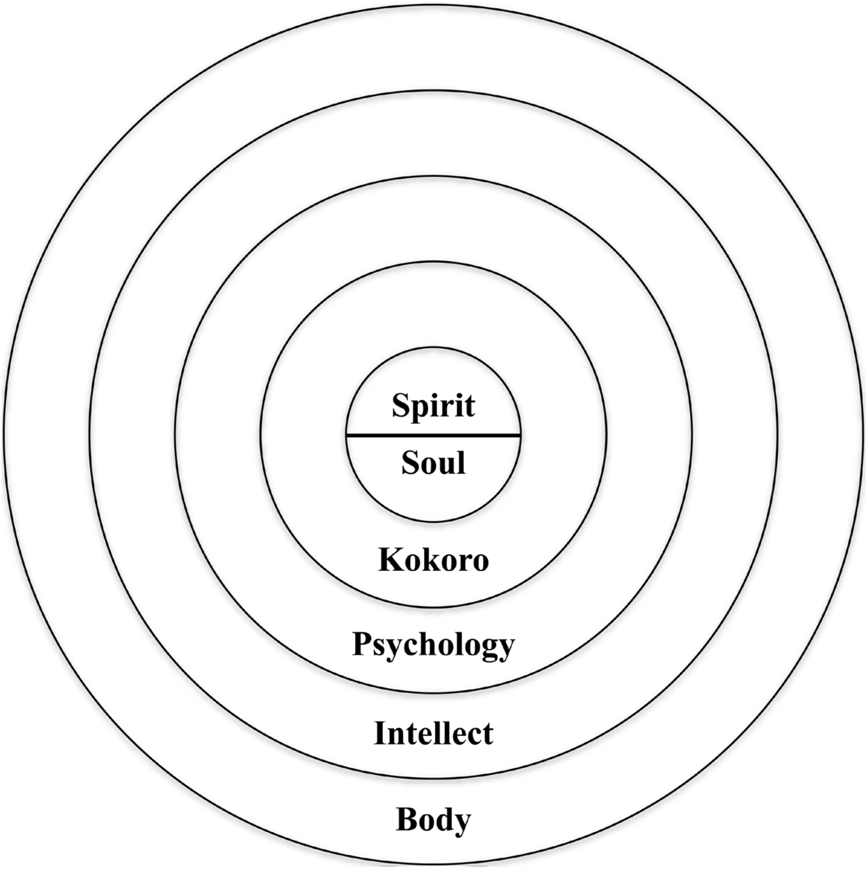

FIGURE 3. Human dimensions (Waldemar Kippes, *Supirichuaru kea: Yamu hito to sono kazoku, yūjin oyobi iryō sutaffu no tame no kokoro no kea* [1999; reprint, Tokyo: San Paolo, 2010], 58).

pointed out that it is often difficult to distinguish between the *kokoro* and the psychological but suggested that the latter was part of a field of scientific inquiry while the former was not. Beyond the psychological lay the intellect (*chisei*), which was firmly lodged in the brain. All of this was then manifested in the physical body (*shintai*).

Kippes stressed in the beginning of his book that all these dimensions were part of one integrated organic body. He further noted that the needs, pains, and cries that arose in each dimension differed and required different approaches for care and cure.[72] But in the remainder of the book, Kippes focused on the "spirit," which he believed to be the primary object of spiritual care.[73] Although he did not use the term "spirituality," he described persons as having a "spiritual existence." Kippes's usage of the term "spiritual" was therefore consistently adjectival, describing that which related to the core object of spiritual care—the spirit. Like Kashiwagi, he conceived the spirit as something that lay *within* the person. It was a discrete component of human *being* alongside the physical and psychological dimensions of personhood.

Murata Hisayuki: Feeling Spiritual Pain

Whereas 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, Murata Hisayuki, focused instead on how spiritual pain *felt*. In other words, Murata explained spiritual pain in terms of its symptoms rather than its etiology. This model proved to be very popular amongst medical workers and his definition of spiritual pain remains one of the most frequently cited in hospice journals. It was also brought up frequently during my interviews with nurses and doctors. Murata, a professor of philosophy, 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*), which includes fear of losing the future and personal reflections on the meaning of life; as relational beings (*kankei sonzai*), which includes fear of loneliness, alienation, and being misunderstood; and as autonomous beings (*jiritsu sonzai*), which includes fears of being physically incapacitated, or becoming a burden on others.[74]

The attraction of Murata's definition was that it made spiritual pain more concrete. Murata's definition of spiritual pain agreed with Kashiwagi and Kippes in that it concerned questions surrounding individual meaning and existence in the face of suffering. However, Murata recognized that unless patients framed their spiritual pain in those exact terms—which they usually did not—it remained hard to detect in clinical practice. His definition helped solve this conundrum by paying closer attention to how meaninglessness was *felt*. This also helped move the definition of spiritual care closer to the *kokoro* care that hospice workers were already practicing and enabled hospice staff to more easily diagnose patients with spiritual pain even when patients did not express their concerns in explicitly existential or religious terms. For instance, one group of nurses utilized Murata's definition to discuss a patient who voiced a deep fear that she would become an object of gossip if her friends became aware of her condition.[75] 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 nonfamily 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 expanded upon Murata's model. For example, Ozawa Taketoshi, a hospice physician, wrote a book in 2008 with the handy title, *Practical Spiritual Care*

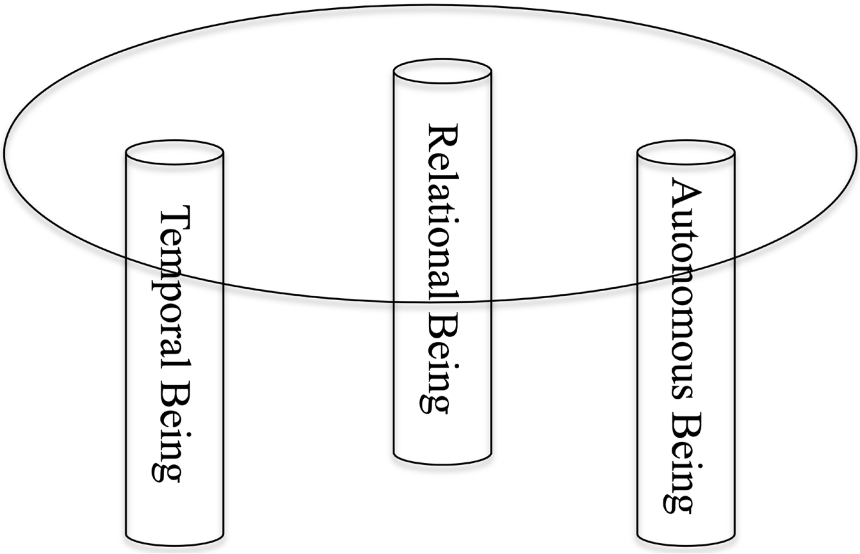

FIGURE 4. Three supports for existence (Ozawa Taketoshi, *Iryōsha no tame no jissen supirichuaru kea* [Tokyo: Nihon Iji Shinpōsha, 2008], 67).

for Medical Workers: Don't Run from Suffering Patients! He explained that his book was based on, and sought to expand on, 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 above diagram (see figure 4).

In Ozawa's diagram, patients are supported by three pillars that are correspond to the three aspects of being outlined by Murata.[76] Ozawa then developed a series of additional diagrams to illustrate how if even 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 happens after 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 was led to realize that there was an afterlife where he or she could reunite with family members, the temporal pillar could be mended and balance is restored. In Ozawa's view, the role of spiritual care was to help keep the patient supported as their existential pillars were weakened at the end of life.

Perhaps the most distinctive aspect of both Murata's and Ozawa's theories of spiritual pain was the lack of a mention of the explicitly religious concerns we find in Kashiwagi's and Kippes's understanding of spiritual pain. Instead, religious concerns were included within the three aspects of being. For instance, when patients felt cut off from a transcendent Being, this was labeled as relational pain. Likewise, questions about the afterlife fell under the category of temporal spiritual pain.

THE TENSION BETWEEN SPIRITUAL AND RELIGIOUS CARE

After some of the parameters for the study of spiritual pain had been set, subsequent leaders in the field of spiritual care sought to more carefully delineate the role that religion played in spiritual care. Buddhist and Christian chaplains were well aware that the success of spiritual care in clinical settings required sensitivity on the part of chaplains to the negative image many Japanese had of religious professionals. At the same time, chaplains could not hide that their religious background and training informed their work. The language of spirituality afforded chaplains a sufficiently benign slogan that helped them walk this tightrope in clinical settings.

Kubotera Toshiyuki: Separating Religious and Spiritual Care

One of the first figures who set about distinguishing religious care from spiritual care and helped set the tone for subsequent models of spiritual care in Japan was Kubotera Toshiyuki, a former chaplain at Yodogawa Christian Hospital. Kubotera was trained as a Christian minister and worked with Kashiwagi 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.[77]

Kubotera also defined spiritual pain as "the pain felt in one's whole existence when the reason and meaning for living is threatened by illness or death." In his view, as patients felt threatened by death, a higher consciousness of "self" raised emotional, philosophical, and religious questions.[78] 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. Kubotera also 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 this stress might lie deeper philosophical doubts, religious questions, and a desire for relief (*kyūsai*).[79] In other words, Kubotera argued that humans naturally seek out God, eternity, meaning, or value in their lives. Kubotera further suggested that when difficulties come, those who have a strong relationship with God were better prepared to cope.[80]

Even though Kubotera believed that religious concerns were an important factor in the spiritual pain of patients, he also maintained that religious care needed to be clearly distinguished from spiritual care. For example, in the following Venn diagram, Kubotera laid out his understanding of "*kokoro* pain" (see figure 5).

As this diagram illustrates, despite some overlap, religious pain and psychological pain are viewed as distinct from spiritual pain. Like most chaplains, Kubotera

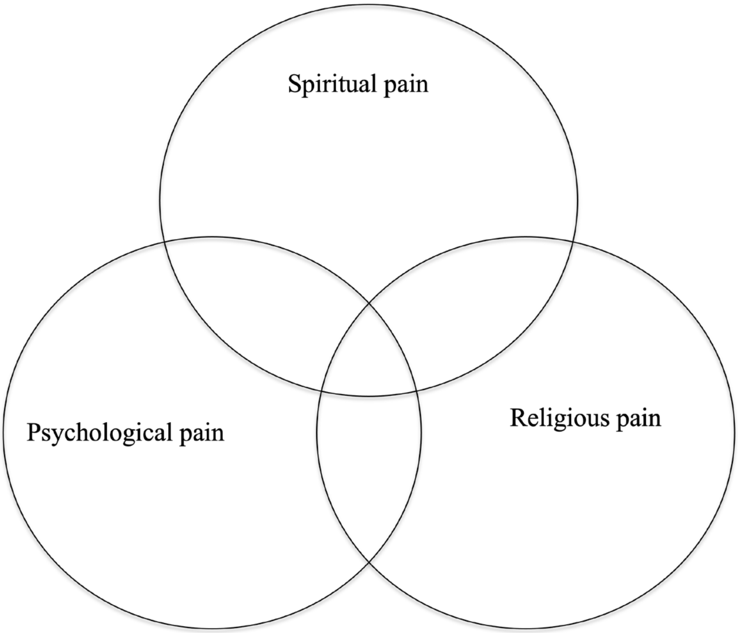

FIGURE 5. *Kokoro* pain (Kubotera Toshiyuki, *Supirichuaru kea gaku josetsu* [Tokyo: Miwa Shoten, 2004], 46).

was opposed to the active proselytization of patients. This would be a serious violation of patient rights. But his opposition was not only due to its unethical nature. Rather, he made the point that religious care was predicated on a very different kind of pain. He explained that while spirituality is centered on "healing" (*iyashi*), religion is centered on "salvation" (*sukui*).[81] In other words, while religious care put forward doctrinal answers to questions of the afterlife, spiritual care affirmed the patients' own beliefs; while religious care might pronounce forgiveness, spiritual care helped patients quietly accept their guilt, help them reflect, or forgive themselves; and while religious care was offered by a religious professional, the provision of spiritual care was not limited to religious experts.

One way that Kubotera was able to mark 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 described spirituality as a "function" (*kinō*) that all humans are born with, and that becomes particularly "awakened" (*kakusei*) in the face of a crisis.[82] In Kubotera's view, spirituality could be described as feelings (*kankaku*), reasons for living (*ikiru konkyo*), 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 how spirituality could provide a framework (*wakugumi*) 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.[83] Interestingly, Kubotera's definition of spirituality as focused on feelings, reasons, and self-identity, in fact mirrors commonly held understandings of the *kokoro* as the seat of emotions, the will, and the self. However, his focus was on spirituality and not the *kokoro*. This is presumably because the term "spirituality" lent itself to more clearly signifying something that could conveniently stand in opposition to, or in relation to religion.

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.[84] 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" (*motometeiru*), "awakes" (*kakusei*), and "sleeps" (*nemutte*).[85] 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*).[86] This shows how spirituality in the Japanese hospice was slowly medicalized into a dimension of *being*.

Tanimaya Yōzō: Spiritual Relationships

Another scholar who emphasized the need to separate religious care from spiritual care was Taniyama Yōzō, a former Vihāra priest turned professor at Tohoku University. Taniyama remains one of the most prominent and prolific Buddhist scholars on the subject of spiritual care and presented the following diagram to explain how spiritual care was structured as a series of relationships (see figure 6).

In this figure, the "self" is located at the center of the circle and is surrounded by eight relations. These include relations with 1. humans (*hito*): family members and friends; 2. the past (*kako*): memories and regrets; 3. the now (*ima*): inner or true self; 4. the future (*mirai*): hopes and despair; 5. things (*koto*): environment, art and music, pets; 6. principles (*ri*): truth, ethics, or morals;[87] 7. divinity (*kami*): God, Buddhas, higher beings; and 8. ancestors (*so*): deceased family members and friends. These relations are further categorized into three dimensions: the transcendent (nos. 6–8), substantial (nos. 1, 5), and inner (nos. 2–4). Taniyama explained that the numbers affixed to each of these relations also represented the order of the most common types of spiritual pain and suggested that most Japanese tend to first value their relations with other people; then with their past, present, and future selves; and finally, with the transcendent.[88]

Like Kubotera, Taniyama made clear that in practice, religious care, which he defined as a type of care in which the patient is invited to participate in the

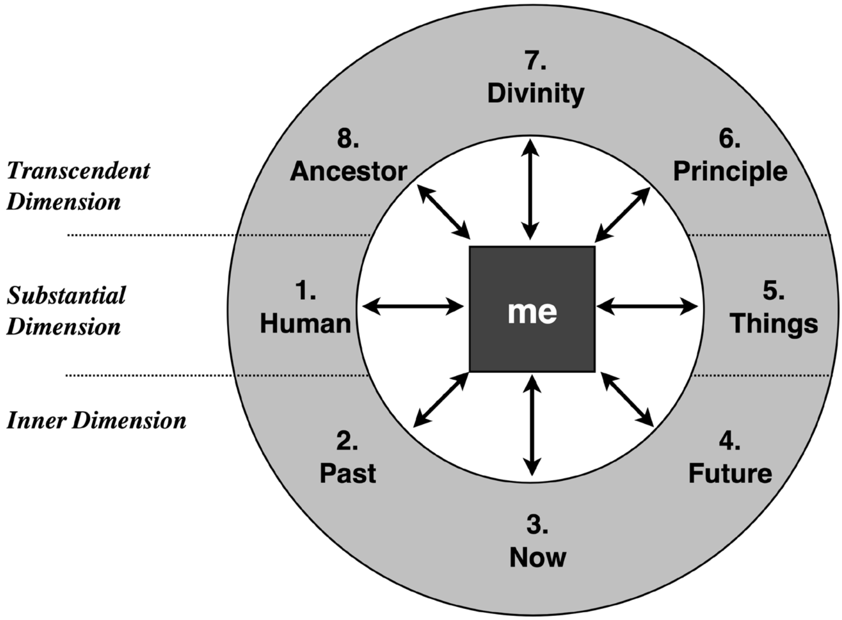

FIGURE 6. The structure of spiritual care (Taniyama Yōzō, "Nihonteki, bukkyōteki yōso o kuwaeta supirichuaru kea ron," *Bukkyō fukushi* 10 [2007]: 77).

caregiver's belief system, should be carefully distinguished from spiritual care, in which the caregiver entered the patients' belief system instead.[89] Taniyama's concern about conflating these approaches was twofold. First, he agreed with Kubotera that there was a real danger of coercing vulnerable patients to adopt the caregiver's religion. When a chaplain or staff member saw a need for religious care, they must first confirm this with the patient before drawing on religious resources to provide such care.[90] Second, and more pragmatically, he also believed that keeping the two distinct in theory was crucial to helping medical staff who viewed religious workers with suspicion appreciate the importance of spiritual care. Maintaining this stance was indispensable to encourage the hiring of chaplains in secular spaces.[91] In Taniyama's diagram of spiritual care, the patient's relationship with something "transcendent," such as gods or ancestors, came last in importance. In other words, while religious care can sometimes be a part of spiritual care, the primary purpose of spiritual care is to help patients in their relationships with others and to support their inner or imagined selves.

Bringing Religion and the Spiritual Back Together

Although figures like Kubotera and Taniyama were careful to distinguish between religious and spiritual care, other figures in Japan's hospice care movement tried to argue more forthrightly for the place of religion in clinical practice. One such scholar was Ōshita Daien. Ōshita, an abbot of the Shingon temple Senkōji in Gifu

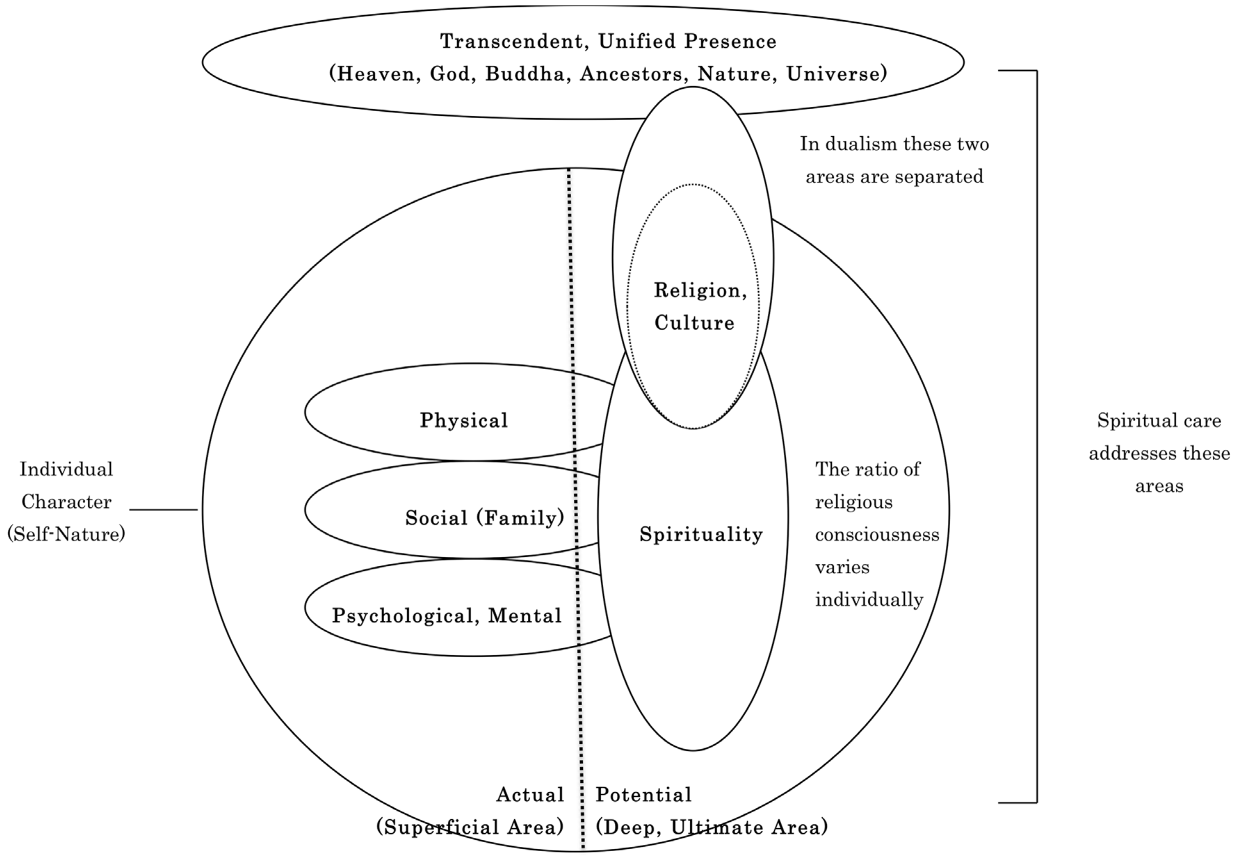

FIGURE 7. Conceptual diagram of spirituality and spiritual care (*Ōshita Daien, Iyashi iyasareru supirichuaru kea: Iryō, fukushi, kyōiku ni ikasu bukkyō no kokoro* [Tokyo: Igakushoin 2005], 2323).

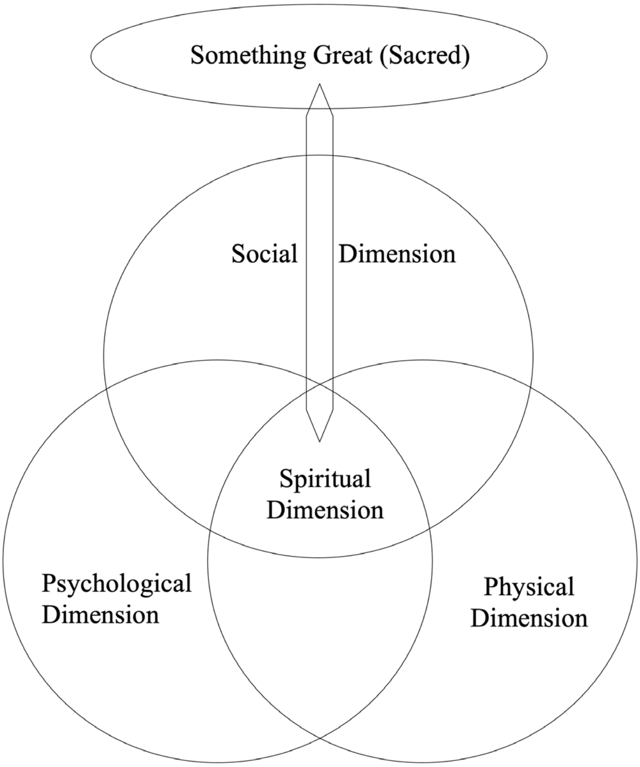

FIGURE 8. The relationship between spirituality and something great (Takagi Yoshiko, "Genba kara mita pasutoraru kea to supirichuaru kea, guriifu kea," in *Kōza supirichuarugaku dai 1kan*, ed. Kamata Toji et al. [Kanagawa: Beingu Netto, 2014], 66).

prefecture, studied on Mount Koya and also in Sri Lanka. Ōshita emphasized that spiritual care should be practiced in society more broadly and not just within the context of the hospice. For example, Ōshita viewed spiritual care and *kokoro* care as analogous. He also sought to move spiritual pain back into the mainstream of *kokoro* care and expand its scope to include society at large.[92] Ōshita also viewed spiritual pain as predicated on a person's spiritual or religious nature. In other words, spiritual pain arose from a "religious mental state" within the person.[93] According to Ōshita, Japanese spirituality looked something like figure 7.

As Ōshita's detailed diagram shows, spirituality was imagined as a dimension of personhood that integrated the physical, social, and psychological aspects of being, and overlapped with a belief in something transcendent. In his view, spirituality was something that integrated the self and formed the basis for a religious consciousness. As for offering religious care to nonreligious patients, unlike Kubotera and Taniyama who were more cautious on this point, Ōshita saw religious care as a distinct but also integral component of spiritual care.[94] He explained: "I think that instead of trying to force a separation between religious care and general

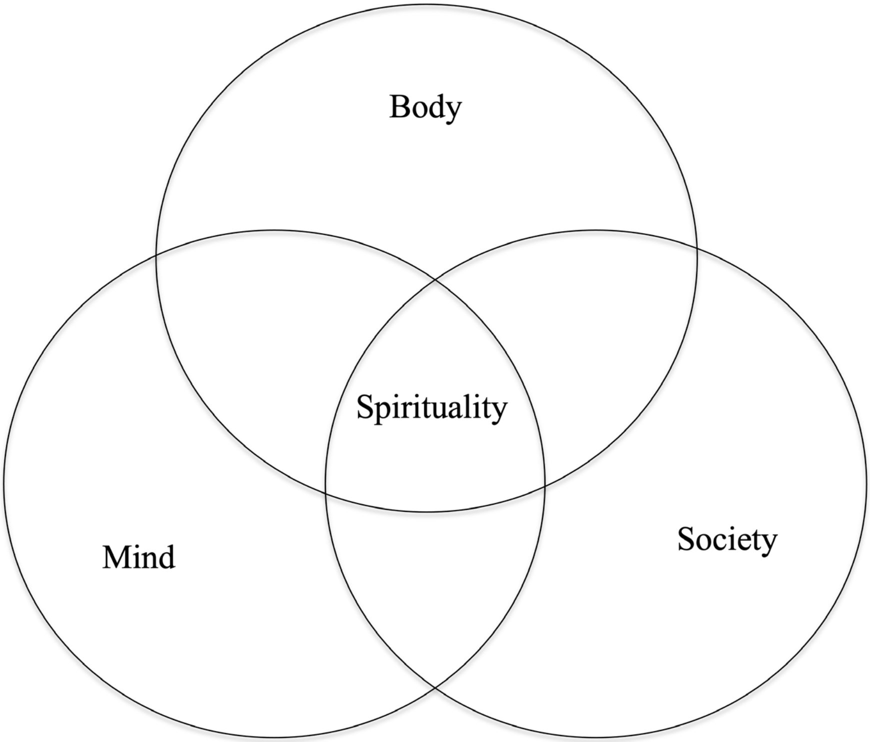

FIGURE 9. The location of spirituality (Yamazaki Fumio, “Ningen sonzai no kōzō kara mita supirichuaru pein,” *Kanwa kea* 15, no. 5 [Sept. 2005]: 378).

spiritual care, it is much more practical in the clinical setting to view religious care as included in the larger area of spiritual care.”[95]

Ōshita’s view of spirituality and spiritual care was quite similar to one diagramed by Takagi Yoshiko, a Catholic sister who served as chair of the board of the Japan Society for Spiritual Care for many years, and taught at the Grief Care Center at Sophia University in Tokyo (see figure 8). It also resembled a diagram drawn by Yamazaki Fumio, the doctor introduced at the very beginning of this chapter (see figure 9).

As these diagrams show, Ōshita, Takagi, and Yamazaki all emphasized that spirituality was the integrating or core element of personhood that also overlapped with the physical and psychosocial dimensions of being.[96] Ōshita and Takagi also agreed that the spiritual dimension was closely connected to something transcendent, sacred, or greater than the individual.

Notably, Yamazaki’s diagram closely resembled Takagi’s, except without reference to something transcendent. Yamazaki’s diagram also echoed the WHO’s definition, which defined the “spiritual” as the “integrating component” of the physical, psychological, and social dimensions of persons. Yamazaki later explained through another sequence of diagrams that the challenging circumstances that accompany death crack into these circles to create physical, 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.

TALKING IN CIRCLES

The Venn diagrams and other figures introduced here are clearly generalizations and work as heuristic devices to clarify the nature of spirituality for Japanese hospice workers who struggle to understand what the term "spiritual" means. Obviously, a diagram is an easier tool for explaining spirituality to a fresh-faced nursing student than a long-winded explication of unstable concepts. After all, 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.[97] Yet at the same time, in addition to being heuristic devices, these images deserve to be examined 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."[98] These diagrams speak to the clinical need to make disease "totalized at last in a motionless, simultaneous picture."[99] 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."[100] These classificatory impulses illustrate the different ways hospice workers conceptualize the relationship between spirituality and religion.

RECONSIDERING THE SPIRITUAL-RELIGIOUS BINARY

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, religious scholars like Shimazono Susumu described 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's and the WHO's explication of total pain but drew more attention to the spirit (*rei*), which he described as lying at the core of spiritual needs. Beginning with Kubotera and Taniyama, however, the existential and religious angst that was awakened in those who were facing dire situations began to be expressed through the English-loan word of "spirituality." 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 downplayed 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 did not preclude religious care but focused on how spiritual pain was felt—an approach that appealed to the vast majority of nonreligious hospice workers who were drawn to its clinical applicability.

What is at stake in these varying interpretations is the question of how spirituality differs from religion. As Horie Norichika has pointed out, the notions of spiritual and spirituality tend to be far more religious in English-speaking contexts 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.[101] 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, 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."[102] This positioning was of vital importance 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.

However, this boundary-making function of the term "spirituality" also made the definition of spiritual care ambiguous, since spirituality in Japan functions as something like a "working hypothesis" (*sagyō kasetsu*) for something that is more than just religious.[103] 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. This ambiguity hinders hospice workers from explaining 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 lacked a tradition of pastoral counseling in medical settings, psychologists have traditionally addressed the types of wider existential questions that chaplains are expected to address in most North American or

European contexts. 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.[104] 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, how can one meaningfully distinguish between psychological and spiritual pain?[105]

Some Japanese hospice workers and scholars have suggested that the distancing of religion within models of spiritual care also amounts to a secularization of spiritual care that not only undermines its ethos and but also demands chaplains to conduct spiritual care in a way that is untenable in practice. For instance, religious scholar Andō Yasunori sees the language of spirituality as a kind of defanged religion that has missed an opportunity to challenge the clinical gaze. 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 psychological 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.[106]

In a similar vein, Fukaya Mie, a scholar of social work, and Shibata Minoru, a Christian hospital chaplain, argued that trying to separate spiritual care and religious care was simply impossible in practice.[107] Based on interviews 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 and suggested that the call for bracketing of religious care in the hospice setting ignores the complex tension chaplains must navigate in their work. On one hand, all chaplains are committed to refrain from proselytizing patients. On the other hand, all chaplains believed that religious beliefs invariably informed their work.

SPIRITUAL CARE IN THE BIGGER PICTURE

The 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 traveled to Europe and the United States to receive training. Kashiwagi was clearly influenced by Cicely Saunders during his travels to England. Kippes brought a German perspective to bear on the subject, and Kubotera received theological training in the United States. But it is also important to note that none of this was a one-way conversation. For example, Murata's definition of spiritual pain has been published in English and has contributed to conversations on spiritual pain in North America as well.[108] Naturally, as ideas travel across linguistic and cultural borders, some things become lost while new things are produced. In the case of spiritual care, differences certainly abound, but what is most surprising is the extent to which the discourses 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 continues to link 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 that were similar to Saunders's, and their division of persons into mind, body, and spirit represented familiar theological ground.

Buddhist hospice workers, in contrast, had reason to challenge these understandings. As Taniyama and other Buddhist scholars have noted, a correct Buddhist approach to spiritual care seeks to illustrate that metaphysical distinctions between the body, mind, society, and spirit are purely conventional.[109] A truly Buddhist theorization of spiritual care would illuminate 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) agree that spiritual pain should be treated differently from religious pain, while Takagi (Christian) and Ōshita (Buddhist) seem to agree that they cannot be easily 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 declining religiosity within Japan, rather than promoting spiritual care from a particular religious perspective, in recent years the proponents of spiritual care have sought legitimation for their work by banding together and promoting a nonconfessional vision for spiritual care.

CONCLUSION

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 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 how spirituality has been medicalized in clinical settings into a dimension of being. In the end, the answer to Yamazaki's initial question at the beginning of this chapter—"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 entangled with 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 articulate the spiritual dimension within palliative care through her introduction of the concept of "total pain"; her four-part definition of personhood was later mirrored in the WHO's definition of palliative care as well. In Japan, although disagreement remained as to what exactly the spiritual dimension represented, the concept of patient spirituality provided Japanese chaplains with a way to negotiate the ambivalent nature of their work: religious experts who were also called upon to minister to patients in nonreligious ways.

The global view that spirituality represents a discrete dimension of personhood also raises the question of whether the differences between humanistic psychotherapy and nonreligious forms 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, a 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*).[110] 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 existential pain (*jitsuzonteki itami*) interchangeably with spiritual pain, the term "spiritual" remains far more popular, even when its meaning is less clear.[111]

The tenor of global clinical conversations on spirituality also exhibits a tendency toward medicalizing the idea of patient 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.[112] The drawback of this approach, which takes the concept of spirituality as a universal category, is its failure to take into account its dynamic discursive or boundary-marking function.[113] Perhaps more importantly, the medicalization 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 remains at odds with Saunders's interest in the concept of total pain in the first place—that is, to treat the person as a whole person.[114]

6

Making Healthy Religion

On a 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, one in particular caught my eye. It was titled *The Reason a Zen Priest Aims to Be a Doctor*. The author was Tsushimoto Sōkun, a former Zen 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*] to play a role.[1]

The view that modern Japanese Buddhist priests only interact with their parishioners during funerary and memorial rites is a stereotype that is hard to shake. In fact, it has dominated public and academic discourse on Japanese Buddhism for well over a century.[2] One way modern Japanese Buddhists have sought to combat this stereotype and emphasize their value to society is by engaging in social welfare activities.

This chapter locates the practice of spiritual care in Japanese hospices within a broader historical narrative of Japanese religious engagement in medicine during the twentieth century. I focus especially on institutionalized forms of social welfare provided by Buddhist and Christian hospitals that showcase the more "public" contributions of religious groups in medical care.[3] Although the Japanese hospice movement did not take off 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 the hospice movement. For example, in the late nineteenth and early twentieth century, Buddhist and Christian groups in Japan were particularly active in building hospitals and medical dispensaries, often legitimizing their work by focusing on medical charity (*jizen*) as both a tenet of religious practice and a symbol of modernization.[4]

These types of activities are connected to contemporary spiritual care in two ways. First, 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 premodern Japan, to promote the contemporary Vihāra movement. Second, religious hospitals established during this period later became key sites for purveying the philosophy of hospice and spiritual care in Japan. Accordingly, 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. 1945–60) to show how these efforts later set the stage for religious involvement in hospice care. In particular, it will demonstrate 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. I 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. This is followed by an analysis of how two key historical events in 1995—the Hanshin earthquake and the sarin gas attack by the religious group Aum Shinrikyō—helped pave the way for the spread of spiritual care in clinical settings more broadly in the twenty-first century.

Ultimately, this chapter will seek to place spiritual care in Japan—in discourse and on the ground—within its broader historical and institutional 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 shows 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. This longer view of Japanese modern religious engagement in medicine also helps to problematize a view that depicts socially engaged Buddhism in Japan as relatively recent phenomena.[5] More importantly, calling attention to the early history of social welfare activities by religious groups helps us better understand the ways Japanese religious groups have taken it upon themselves to try and play a “healthier” role in society.

MOBILIZING HISTORY: IMAGINING A "GOLDEN ERA" OF BUDDHIST MEDICAL WELFARE

Inoue Enryō (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 jigyō*). 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*], we can say that we have not even begun to undertake this. Although Buddhism originally had charity at its basis [*moto*], and it has been understood that the Buddha mind [*busshin*] is to have great compassion [*daijihi*], though compassionate, in fact, the lack of charitable works is something I find truly hard to comprehend.

Inoue then went 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."[6] In this passage Inoue links the success of Christianity in the West to its charitable work for the benefit of others (*ritateki jizen jigyō*). Inoue also critiques Japanese Buddhists for only conducting charitable work that had some self-interest involved (*jiriteki jizen jigyō*) and warns that Buddhist groups may fall behind their Christian rivals in Japan.

Not all Buddhists were as explicit as Inoue in using Christian charity work as a foil for furthering a vision of Buddhist social welfare, but this passage shows the palpable sentiment among Buddhist reformers in the Meiji period that Buddhism had "degenerated" from its lofty teachings. According to this now well-trod 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.[7] 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.

Since there was a strong view among 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 social welfare.[8] Much of this historiographical discourse on religion and social welfare in Japan is embedded in a vision of reforming Buddhism to emphasize its contributions to contemporary society. For example, Tsuji Zennosuke (1877–1955), a professor at Tokyo Imperial University and Japan's preeminent prewar Buddhist historian, was one of the most influential voices in the discourse of Buddhist "degeneration." As part of his effort to show just how far Buddhism had fallen, he published a thick volume titled *Historical Records of Charity and Relief* (Jizen kyūsai shiryō; 1932), which began as a project to collect historical documents for display at a charity hospital in 1919. Beginning with the earliest records of Japanese history and continuing up until the Meiji Restoration, Tsuji's book was a chronological anthology of records of charitable works, often by Buddhists, in Japanese history. Likewise, Asano Kenshin (1898–1939) published a similar volume titled *The History of Buddhist Social Work in Japan* (Nihon bukkyō shakai jigyō-shi; 1934) that highlighted the social work undertaken by past Buddhists. Asano wrote 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."[9] 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. His book sought to emphasize Buddhism's own long tradition of social work activities.[10]

The growing Buddhist interest in playing a more active role in social welfare was also expressed in the monthly Buddhist journal *Kyūsai* (Relief), which was published between 1911 and 1919 by the Jōdo Shinshū Ōtani Sect Charity Association. This journal featured numerous articles on historical examples of Buddhist social work as well as news reports about recent social welfare activities in Japan. The first issue of this journal explained that underlying the formation of the association and the journal was a strong consciousness of charitable works as "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."[11]

Invoking past examples of Buddhist charity and social work, as well as referencing the contemporary work of Christians, helped inform the call by reform-minded Buddhist priests for greater social engagement. In other words, Inoue Enryō's early perception that Buddhism had become "corrupt," abandoning its premodern 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 welfare. At the same time, such precedents also allowed reformists to promote a vision for increased social engagement by invoking the supposed lapses of modern Buddhism. This imagining of the past "golden era" of social welfare authorized and naturalized contemporary 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. This two-pronged approach 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. As Mark Rowe notes, the "give it your best, Buddhism!" (*gambare Bukkyō!*) approach of scholars who hearken back to the golden era of Buddhism or highlight the innovative activities taken by a few contemporary Buddhists only serves to amplify the narrative of degeneration.[12] It is this narrative that motivates a twentieth-century Zen priest to become a doctor: the fear that twenty-first-century parishioners will otherwise "only expect us to conduct funerals and memorial services."

BUDDHIST DEATHBED RITUALS AS A PRECEDENT FOR HOSPICE CARE

A more specific inspiration for Buddhist engagement in contemporary hospice and spiritual care comes from the premodern Buddhist practice of "deathbed rituals" (*rinjū gyōgi*), which provided dying persons in medieval and early modern Japan with a set of ritual tools to maintain a state of right mindfulness (*shōnen*) at the moment of their death. These rites were performed to ensure an auspicious rebirth in the next life. To ensure right mindfulness, a spiritual companion called a "good friend" (*zenchishiki*) often assisted the dying by helping them to chant a prayer to the Buddha (*nenbutsu*) in their last days and hours, providing encouragement and managing the deathbed environment so that it was conducive to right mindfulness.[13] What made these premodern deathbed rites especially appealing to modern proponents of spiritual care was the image of a Buddhist priest helping dying persons reach a state of spiritual equanimity during their last days. For instance, a collection of deathbed ritual texts edited by one of the founders of the Vihāra movement makes a direct correlation between these practices and modern hospice care in the book *Deathbed Rituals: The Origins of Japanese Terminal Care*.[14] The former head of the Nichiren Vihāra Network also refers to the early seventeenth-century deathbed ritual text as having "content rich in suggestions for us today despite its historical background in the early Edo period,"[15] while another contemporary study of esoteric deathbed ritual texts suggests that both medieval deathbed rituals and contemporary palliative care share the common goal of seeking a "desirable death."[16]

On the surface, it might seem strange that modern Buddhists sought to distance themselves from stereotypes of "funerary Buddhism" by stressing their historical expertise in care for the dying. After all, was not care for the dying on the same continuum as care for the dead? In the case of hospice care, however, the primary difference was monetary. Since funerary rituals are notoriously expensive in Japan, the Buddhist priest was often cast in the popular media as a greedy figure that only appears at the parishioners' homes after they die. In a memorable scene from Itami Juzo's 1984 film *The Funeral*, a Buddhist priest arrives in a fancy limousine to conduct a funeral. In contrast, the Vihāra movement has thus far shown an absence of financial motives and relies heavily on the work of volunteers. Even still, the so-called links between deathbed rituals and contemporary hospice care can generate confusion on the role of contemporary Buddhists in spiritual care. To be sure, drawing attention to the history of deathbed rituals helps to show that Buddhist priests were historically more than just funerary ritualists. But premodern deathbed rituals also differ in significant ways from the practice of spiritual care in contemporary hospices. For example, medieval deathbed ritual texts often instruct the accompanying priest to exclude family members from the deathbed since their presence might arouse thoughts of emotional attachment and thus hinder the dying from attaining right mindfulness. Such instructions show how deathbed rituals 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 premodern deathbed rituals were also much higher than today. Japanese in the medieval period were painfully aware that not dying in a state of right mindfulness opened the possibility of being reborn into hells or other undesirable realms. In contrast, with a few exceptions, hospice patients in Japan today only rarely raise such concerns. Despite these differences, since deathbed rituals provide the closest premodern analogy to spiritual care, they are often invoked by contemporary Buddhists as the origins of Japanese Buddhist spiritual care.

THE ROLE OF CHRISTIAN MEDICAL MISSIONS

Although Buddhism has a longer history of medical welfare activities in Japan, a case could be made that Christian medical missions in modern Japan had a much stronger impact on 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.[17] The initial impact of Christian medical missions can be traced to the period from 1823 to 1910, when it is estimated that more than two hundred foreign 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.[18] Although the rapid acquisition of modern medicine in Japan eventually eclipsed the need for medical missions, the marks that missionaries left on the medical field in Japan were 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.[19]

By 1883, eighteen Christian medical missionaries had arrived in Japan.[20] Yet it was not certain if they were really needed. 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.[21]

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."[22]

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 from the American Board of Commissioners for Foreign Missions, noted that while medical assistance had been helpful in the past, such assistance would now "not only be considered of doubtful propriety but would be a burden rather than a help."[23] 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 removed the necessity for foreign physicians. In contrast to Palm, however, Taylor went on to qualify his remarks by suggesting a need for medical work among the poor.[24] Although Palm had warned seventeen years earlier against introducing a "pauperizing system into Christian hospitals," Taylor presented a favorable view of charity hospitals.[25]

> 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.[26]

Taylor calculated that while 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.[27] Taylor went on to claim, "Japan has scarcely made more than a beginning in the highest form of civilized and Christian benevolence, that of medical charities."[28] 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.[29] 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.[30]

BUDDHIST MEDICAL MISSIONS

Even as Christian medical missionaries played a prominent role in Meiji era medical work, Buddhist groups were not far behind. For example, the establishment of the Kyoto Ryō Hospital in 1872 was made possible with the support of Buddhist leaders of the Jōdo and Rinzai sects and Japan's first public psychiatric hospital was established on the temple grounds of Nanzenji in 1875.[31] Beginning in the late 1880s, a string of Buddhist medical dispensaries began offering medical relief.[32] In 1909, for instance, the Saisei Hospital was established on the grounds of Tōji temple in Kyoto by the Shingon association Sofū Senyōkai (lit., "Association for Enhancing Our Founder's Teachings") and became one of the most prominent Buddhist charity hospitals of the Meiji period.[33] In its first four years, the Saisei Hospital treated 18,159 new patients.[34] The Sofū Senyōkai itself was 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* through the mutual interdependence of the medical way and religion."[35] As this statement shows, care for the *kokoro* of patients was on the minds of religious groups well before the notion of spiritual care was later developed in the hospice context.

Like their Christian counterparts, many Buddhists framed the importance of their medical work as charity. For example, the Saisei Hospital declared itself willing to follow the example of its Shingon patriarch Kūkai in practicing compassion and saving the world (*jiai saisei*) by not seeking payments from patients, although sincere donations would be accepted.[36] 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 and a half million yen for the establishment of the Saisei Association (Saiseikai) to provide medical services to the poor and needy of Japan. This event was widely reported on in the press and galvanized Buddhists to provide even more medical relief. It also propelled the publication of the Buddhist social welfare journal *Kyūsai* between 1911 and 1919, which provided a forum for reform-minded Buddhists to discuss the importance of social welfare.[37]

OUTGIVING 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 charitable activities remained an important motivating force for social engagement.[38] Christian missionaries also lambasted Buddhists for not doing enough. In 1915, Sidney Gulick 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."[39]

Such statements paint a pessimistic picture of Buddhist engagement in social welfare during 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).[40] On the Christian side, Yajima Yutaka counts only 124 Christian social welfare institutions that were founded during the same period.[41] 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.[42] In terms of medical services, however, it seems that the Buddhist efforts did lag behind Christians. The Jōdo sect embraced the slogan, "one temple, one social service" (*ichi jiin ichi jigyō*) in the 1930s, but in reality most temples could at best only afford to provide religious edification or education activities (*kyōka katsudō*) and local childcare.[43] 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 limited to religious education activities or childcare, and less than one percent of the listed institutions provided medical care.[44]

These numbers also do not reflect the overall quality of social-welfare activities. For instance, Christian missionary Wallace Taylor bemoaned the lack of asylums for the blind, deaf, and dumb and homes for sufferers of leprosy in his report to missionaries in 1900. Although he acknowledged that such asylums existed, he dismissed 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."[45] 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*) in the early Meiji period.[46] In some cases, Christians literally "filled in" for the Buddhists by establishing social welfare institutions in vacant temples.[47] The combination of Buddhist financial struggles, and the financial support that Christian medical missionaries enjoyed from their home supporters, became an important reason why so many Christian medical institutions were established in early twentieth-century Japan.

RELIGIOUS MEDICAL WELFARE IN THE POSTWAR JAPAN

The economic devastation left in the wake of the Second World War gave rise to further 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.[48] This was the same hospital that would later play a leading role 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."[49] 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 needy area of Osaka 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.[50]

In a letter of reply to the local medical association, the missionaries assured local doctors that the hospital would start with about twenty beds and not attempt to compete with local medical facilities, but rather endeavor to be "of aid" for "unmet needs."[51] Local doctors were initially skeptical. However, by 1958, they were won over and eventually invited Yodogawa Christian Hospital to join the local medical association.[52]

After 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 were ninety-three medical institutions in Japan that were affiliated with Christian groups or operated with a Christian mission statement.[53] Forty-five qualified as hospitals (*byōin*), meaning they had at least twenty beds, while the rest were 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 they founded remained. By this point, however, Christian hospitals like 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, Yodogawa's mission statement declared that their hospital was "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."[54]

This statement was later shortened to 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 (*karada*), mind (*kokoro*), and spirit (*tamashii*)." The inclusion of "spiritual needs" of patients and the focus on "whole person healing" in this mission statement later helped position Yodogawa Christian Hospital to be at the forefront of the spiritual care movement.

On the Buddhist side, medical welfare and charitable activities after the immediate postwar period slowed down as well.[55] 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.[56] For instance, in 2006 the Honganji branch of Jōdo Shinshū listed 859 social welfare facilities, including 726 nursery schools and eighty-nine elder care facilities. Significantly, no hospitals or clinics were listed.[57] To my knowledge, there are currently only a handful of hospitals today that are publicly affiliated with Buddhist groups or operate under Buddhist principles.[58] 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 (established 1902) only remained open for several years. Even the largely successful Saisei hospital at Tōji (established 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.[59]

In contrast, many Christian hospitals remained open even as their missional emphasis turned from charity to holistic healing, and eventually expanded to include hospice care. 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.[60] Many of these hospitals employed Christian doctors, had Christian mission statements that emphasized spiritual as well as physical healing, and had hospital chaplains on staff who were available to lead chapel services and visit patients. This existing infrastructure, plus the overseas ties that many Christian hospitals held through their religious affiliation, were instrumental in paving the way for the establishment of hospice care at these institutions.

Although they have not been a focal point of this study, new religious groups in Japan were also active in medical welfare throughout the twentieth century. For instance, the roots of Tenrikyō's large hospital in Nara go back to 1935. This hospital was expanded to a six-hundred-bed hospital in 1966, and a hospice was finally established in 2018. Like many other religious hospitals, the Tenrikyō hospital espouses a mission for holistic medicine that attends to the "body, *kokoro*, and manner of living" (*karada, kokoro, kurashi*) of patients. Likewise, the Risshō Kōseikai established a hospital in 1952 and eventually its own hospice in 2004. There too, the hospital adheres to the mission of holistic medicine that treats the "body, *kokoro*, and life" (*karada, kokoro, inochi*) of all patients.

Interestingly, although relatively recently formed religious groups like Tenrikyō and Risshō Kōseikai have been historically viewed with suspicion by the Japanese public, it did not follow that their medical welfare activities were only aimed at helping improve their public image. For instance, since the early twentieth century, Tenrikyō believers have been proactive in providing social and medical services for those who suffered from Hansen's disease. But those who engaged in such activities typically framed their work in terms of concern for the betterment of the less fortunate, or of their own spiritual development, rather than of trying to demonstrate their worth to society.[61] Similarly, recent ethnographic work on the Risshō Kōseikai has drawn attention to how their social welfare activities are not just instrumental actions aimed at self-benefit, but integrate both self-benefit and altruism in complex ways that defy simplistic judgments about their aims.[62] Social welfare activities like the building of hospitals are seen as "a way to put their faith into practice" (*shinkō o jitsugen shite iru*).[63]

Overall, however, the establishment by religious groups of hospitals, clinics, as well as other social welfare institutions helped show the "healthy" role they were playing in society. Many groups initially mobilized and justified their work in medical missions by focusing on the importance of charity (*jizen*) as both a tenet of religious practice and a symbol of modernization. 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 modern medicine by Japanese in the prewar period, and the extension of the National Health Insurance program in the later postwar period, eclipsed the importance of medical missions as a form of charity. But many of the hospitals remained and eventually became important training sites for the introduction of hospice care and the development of spiritual care.

THE BIRTH 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 bestselling book *On Death and Dying* (1969) was translated into Japanese in 1971. One of the pioneers in the Japanese hospice movement was Kashiwagi Tetsuo, the Christian psychiatrist who worked at Yodogawa Christian Hospital. In 1973, a year after Kashiwagi returned from his medical residency at Washington University in St. Louis, he encountered a dying patient in Japan whom he referred to as S. S was experiencing extreme anxiety about death and was referred to Kashiwagi by a colleague. As Kashiwagi spoke with S, he realized that no doctor could treat this patient without additional help since he 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 decided to create a similar team at Yodogawa Christian Hospital, which 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.[64]

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 Cicely Saunders. Kashiwagi explains that during his visits, Saunders checked his impulse as a Christian psychiatrist to focus 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

FIGURE 10. Japan's first official hospice (Photo by author).

> 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.[65]

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.[66] This marked the beginning of Kashiwagi's prolific publishing career that proceeded at the pace of about one book per year.

In the meantime, others in Japan were becoming active in promoting hospice care as well. In 1974, Kawano Hiroomi (1928–2003), a Christian physician, published a book on support for the dying and in 1978 founded the Japanese Association for Clinical Research on Death and Dying, which continues to host Japan's flagship conference on hospice care. In the same year, the Japan Society for Dying with Dignity was founded, and the establishment of hospice care was set as one of its goals.[67] At last, Japan's first official hospice opened in 1981 at Seirei Mikatahara Hospital in Shizuoka. Seirei Mikatahara Hospital was founded by the Christian activist and politician Hasegawa Tamotsu (1903–94) in 1930, and the hospital upholds the mission of "neighborly love based on the Christian spirit."[68]

After gathering sufficient funds, Yodogawa Christian Hospital opened Japan's second hospice under Kashiwagi's supervision three years later in 1984.

It is important to note that to this day, Yodogawa Christian Hospital remains a religious corporation (*shūkyō hōjin*) under the jurisdiction of the Presbyterian Church, USA, and is staffed by several full-time chaplains who visit patients and conduct chapel services while upholding their mission of "whole person healing." 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 nonreligious hospice opened at Kokuritsu Ryōyōjo Matsudo Hospital, which eventually became part of the National Cancer Center in Chiba. In contrast to the first two Christian hospitals, Kokuritsu Ryōyōjo Matsudo was a public hospital and it was reportedly difficult for religious workers to be involved in the care of patients. Instead, they made sure to provide plentiful greenery and wild birds to help patients relax their *kokoro*.[69] In 1989, a fourth hospice was begun at the Christian Salvation Army Kiyose Hospital in Tokyo, and in 1990, a doctor who also pastored a local church established Japan's fifth hospice at Eikoh Hospital in Fukuoka. At this point, four out of the five earliest hospices in Japan were founded at Christian hospitals. But 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 also published his national bestseller, *Dying in a Japanese Hospital*, 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 2020, the total number of hospices in Japan reached 453. Approximately thirty-three of these remain affiliated with Christian hospitals, most of which employ Christian chaplains who provide spiritual care.

THE VIHĀRA MOVEMENT

On the Buddhist side, the Vihāra movement unfolded soon 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; NBSFG). In his essay, 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 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* at the end of life.[70]

As the hospice movement gathered momentum, articles on the need for religious care of the dying 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.[71] Two years later, a survey reported on what eighty-one hospital superintendents and head nurses from hospitals in Kyoto thought of having religious workers serve on their medical teams. Somewhat disappointingly for the author, approximately 70% of hospitals felt holding religious services within the hospital was unnecessary, and only 10% felt it was "absolutely necessary" for religious workers to join the medical team. In contrast, 80% of those surveyed were in favor of religious workers visiting patients who subscribed to a particular religion.[72] 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 again in 1990.[73]

The first big step toward Buddhist involvement in hospice care was taken in 1985, when Tamiya Masashi (1947–) used the Sanskrit term "Vihāra" (Bihāra), to refer to Buddhist hospice care.[74] 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 premodern examples of medical welfare and deathbed rituals.[75] Tamiya also hoped the term would spark a nonsectarian 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 nonsectarian Buddhist Information Center (Bukkyō Jōhō Sentā) formed the Buddhist Hospice Association.[76] This group was spearheaded by Koizumi Keishin (1949–), a Jōdo Shinshū priest who had lived for thirteen years in Hawaiʻi 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 belonged to nominally Buddhist families. 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 further observing, "the Buddhist hospice suited our attempts to show our concern for the living."[77] 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.[78] 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.[79] 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.[80] Meanwhile, Tashiro Shunkō (1952–), a professor at Dōhō University in Nagoya, also formed 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 their public seminars drew three times that number.[81] In Kyūshū, medical doctor Tabata Masahisa (1949–) also began the Kunisaki Vihāra Society in 1990, and helped orchestrate study classes on the *Tannishō*, a work said to record the teachings of the Jōdo Shinshū founder Shinran (1173–1263), as an opportunity to think about death and dying.[82]

When Japan's first Vihāra ward was established in 1992, it was initially greeted with much fanfare and was even featured in a nationally televised documentary program.[83] But despite high expectations, a second Vihāra ward was not established for another decade. In 2004, the new lay Buddhist group Risshō Kōseikai launched a hospice at the Risshō Kōseikai Hospital (established 1952) in Tokyo. 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.[84] However, the movement also expanded to include new directions. For instance, although the official goals of the Vihāra movement initially stated a concern for "dealing with life [*inochi*] 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*] in society."[85] According to a twenty-year review of the Vihāra movement within the Honganji sect, the first two decades of the Vihāra movement could be divided into three periods: the creation of Vihāra (1986–89); the development of regional Vihāra groups (1990–2000); and the reconsideration of Vihāra (2001–8).[86]

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, 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.[87] 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 *kokoro* down the road. 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 lend a listening ear to the elderly or patients, orchestrate recreational events, and even fix wheelchairs.[88]

Since entering the twenty-first century, however, the Vihāra movement has outgrown the hospice ward. For example, Vihāra activities now also include the distribution of food after natural disasters.[89] The broadening of Vihāra activities from the hospice setting can also be seen in the activities of Vihāra 21, a grassroots nonprofit organization affiliated with the Ōtani branch of Jōdo Shinshū, which oversees housing and day services for the elderly and disabled in Osaka.[90] 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, 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.[91] Taniyama suggests that most people use the first two definitions, but in practice, most current Vihāra activities fall into the latter two.

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. This was the year of the Aum sarin-gas attack, but it was also a low point for Japanese religion in another way. Two months prior to the Aum incident, a deadly earthquake hit the city of Kobe and its environs, which claimed more than six thousand lives. In the immediate aftermath of the disaster, religious groups were largely unprepared to support the victims. As one newspaper editorial lamented at the time:

> 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.[92]

Spurred by such criticism, Japanese religious groups began to think in earnest about how they could play a larger role in social welfare activities.[93] When the 1998 Nonprofit Organization Law was passed, this opened the door for religious groups to involve themselves more actively with nonprofit 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.[94]

In addition to helping spur religious groups to seek ways to play a more decidedly "healthy" role in Japanese society more broadly, the events of 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* of those traumatized by personal tragedies, natural disasters, or impending death. *Kokoro* care was originally associated with the holistic philosophy of hospice care that placed value on caring for patients not only physically, but also socially, emotionally, and spiritually.[95] 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. He was only able to receive *kokoro* care from two other patients, who were members of the religious groups Konkōkyō and Tenrikyō and who could encourage him in his faith during his hospitalization.[96] 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*) and existing Christian hospices were referenced for their ability to provide "*kokoro* medicine" (*kokoro no iryō*).[97] A search in the *Asahi* newspaper database shows that the four earliest mentions of *kokoro* care all arise in the context of care for the dying. As these early occurrences show, *kokoro* care before 1995 was closely associated with hospice care. 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, references to *kokoro* care 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*) 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 1% of all funds donated by private and government sources toward disaster victims would be earmarked for the establishment of a "Kokoro Care Center."[98]

This mainstreaming of *kokoro* care after the Hanshin earthquake allowed for wider societal recognition of and interest in a type of care that went beyond biomedical approaches for suffering individuals who faced traumatic experiences related to disaster and death. Around the same time that *kokoro* care went mainstream, religious workers in hospice care started to rely on the label of "spiritual care" to distinguish their work from this broader type of psychological care. As *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 dying. The introduction of the term "spiritual care" 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 further entrenched in hospice care through the establishment of several spiritual care training programs. 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 chaplaincy training and allow for the recognition of spiritual care in Japan as a profession in its own right. The late 1990s also marked the beginnings of a growth in academic and clinical attention to the subject of "spirituality" and "spiritual care" that gained even more momentum after the 2011 earthquake and tsunami disaster led even greater numbers of religious professionals to seek out ways to play a healthy role in society.

HEALTHY RELIGION

The first and more familiar type of "healthy religion" is when religion brings some healthy benefit to individuals. For many centuries, religions in Japan have offered health benefits to its practitioners and continue to do so, whether it be through healing or protective amulets, joining a new religious movement, or practicing mindfulness in one's spare time. This type of healthy religion holds true in hospice care as well where religion is sometimes discussed like a kind of spiritual painkiller. As Marx has famously pointed out, religion can function as a kind of opium.[99] This is not to say that religion is simply an addictive drug. In Marx's day, opium was commonly used as an analgesic. As such, even though Marx held religion to be ultimately harmful, he also pointed out that religion can also help dull the pain of oppressed, heartless, and soulless conditions. In hospice care, where opiates are still used frequently, religious care is sometimes described in almost those exact terms as something that can help take away or soothe "spiritual pain." In fact, it is not uncommon for a doctor to prescribe both spiritual care and morphine at the same time to a suffering patient.

Healthy religion is also about making religion itself healthy or taking on some healthy role in society. In other words, it is not just about religion making sick people healthy, but using the care for sick people as an opportunity to make religion healthy. Although the primary role of spiritual care is to help the dying, it is at the same time closely intertwined with a broader project that seeks to rehabilitate religion in the public sphere. For instance, as Tsushimoto Sōkun, the former Zen abbot mentioned as the beginning of this chapter, explained, part of the motivation for his new career path in medicine was to "contribute to society" so that parishioners won't only "expect us to conduct funerals and memorial services." A more recent example of this vision of Buddhists playing a more prominent role in clinical settings is found in a small group that calls itself in English the "Institute for Engaged Buddhism," or directly translated, "Institute for Clinical Buddhism" (Rinshō Bukkyō Kenkyūjo). An even more literal translation would be, "Institute for Bedside Buddhists."[100] Their website makes clear that this group is not only pursuing research about Buddhism in clinical settings. Rather, their aims are quite broad and include education activities and wider research on how religion can contribute more broadly to the public good of society.[101] These disparate activities are all gathered under the label of "clinical Buddhism."

This project of rehabilitating religion in the public sphere through health work has also been picked up by some parts of the Japanese mass media. For example, in 2016 a primetime documentary on the work of Japanese hospital chaplains aired on Japan's national television network (NHK). In the opening segment, the announcer's voice overlaid a video clip of a dying woman with her hands clasped together while a chaplain stayed by her side. "A terminally ill woman. After death, where will she go? In order to take away anxiety toward death, there are specially trained religious professionals. Right now, throughout hospitals and care facilities in Japan, medicine and religion are working together to achieve peaceful deaths."[102] This positive image of medicine and religion working hand in hand would have been unthinkable in the late 1990s when the public image of religion in Japan was at an all-time low. However, in recent years the media narrative has changed its tune from negative portrayals of religion to portrayals of religion as a kind of "therapy."[103]

Many religious groups have sought to gain entry into modern medical spaces and draw on clinical language to define their mission of social engagement. However, it is important to stress that the synergy between religion and modern medicine in Japan is not at all a new phenomenon. While it is tempting for religious professionals to discuss spiritual care as a new opportunity for socially engaged Buddhism, there is a need to be more cautious about this narrative and to acknowledge that religious engagement in modern medicine is rooted in a longer history. As detailed in the earlier part of this chapter, religious groups have been active in medical institutions through most of the twentieth century. Even the idea of spiritual care is not necessarily new. For instance, as early as 1909, the Buddhist medical hospital established by the Sōfu Senyōkai had set as its goal "to heal the illnesses of the body and *kokoro* [*shinshin nimen*] through the mutual interdependence of the medical way and religion."[104] A longer historical perspective shows that concern and care for the *kokoro* of patients was fundamental to religious involvement in modern medicine from the very beginning.

CONCLUSION

The history of 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 doctor like Tsushimoto Sōkun, over the course of the twentieth century, Buddhists have continued to decry their own lack of social engagement and 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 premodern precedents, such as the practice of deathbed rituals, to underscore their historical expertise in care for the dying. The historical continuity between premodern and modern Buddhist medical welfare and between deathbed rituals and contemporary hospice care is largely imagined. Instead, modern notions of medical welfare are more closely linked to ancillary developments that began in the Meiji period, including the spread of modern medicine, urbanization, industrialization, and political policies that undercut the authority of local Buddhist temples. Nevertheless, Buddhist historical expertise in matters of health and care for the dying more broadly provides a powerful discursive tool to combat modern stereotypes 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.

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 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 fact, many Buddhist chaplains I spoke with mentioned how patients and families would often consult them for advice on funeral arrangements. Funerals can even become an important site for bereavement care. At the 2015 Buddhist Nursing Vihāra Conference, for example, a Nichiren priest 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 the deceased during the wake. This priest 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. However, the Vihāra movement has largely avoided making a public case for involvement in hospice work on the reasoning that they are already funerary specialists. 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. Hence, the importance of hearkening back to deathbed rituals to show that Buddhists originally played a role in care for the dying, and not just the already dead.

Another theme in the history of medical welfare and hospice care in Japan is the important role played by religious hospitals, and particularly Christian hospitals, which helped establish and popularize hospice and spiritual care. Christian medical missionaries in late nineteenth- and early twentieth-century Japan played an active role in establishing medical institutions, some of which have grown to become prestigious hospitals today. Although modern medicine quickly became commonplace, Christian medical missionaries worked alongside native Japanese Christians to establish hospitals with charitable missions. These hospitals then went on to become the primary sites for the introduction of hospice care in the 1980s. Although Christian hospices today only represent 8% of all Japanese hospice wards, their pioneering efforts allowed them to play a disproportionate role in dictating the early philosophy of hospice care, and especially in developing models of spiritual care. 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."[105] At Yodogawa Christian Hospital, which pioneered hospice care in Japan, the chaplain's office was originally known as the Evangelization Department (Dendōbu) before later adopting the less imposing appellation of Chaplain's Office (Chapurenshitsu). Christian doctors like Kashiwagi Tetsuo were also influential in framing the importance of hospice care in terms of the mission statements espoused by their hospitals. This 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 separate Buddhist model of hospice and spiritual care.

More broadly, the history of medical welfare and hospice care in Japan also shows how religious groups in Japan looked to such engagement, both to show their own healthy role in society and to live out their religious commitments of showing compassion and charity to those in need. This emphasis on healthy engagement intensified after 1995, a year when two events—the Hanshin earthquake and Aum Shinrikyō's sarin-gas attack on the Tokyo subway—had seismic repercussions for religious groups by 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.

In closing, it is important to note that even as religious professionals try to expand the vocation of hospice chaplaincy and are vocal about the benefits of spiritual care, religious engagement in medicine remains a small field within Japan's much 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 were recorded on their website in 2017.[106] This suggests that there is a danger in overstating the actual interest that some religious groups have in actualizing programs of care for the dying at a broader level. As Levi McLaughlin has noted, even though 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."[107] 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 views or activities of all its members, and especially marginalized religious groups. Even so, the alacrity with which some parts of the Japanese media and academic establishment have embraced the vision of religious care for the dying is remarkable to see. A mere two decades ago, the public image of religious groups was at an all-time low. Yet public opinion may be slowly shifting—perhaps in part because of the efforts of spiritual care staff who have worked to advance a vision for religion to play a healthy role in Japanese society.

7

Last Thoughts

I had just finished my last interview for the day. As I slipped my notes into a clear file and returned the recording device to my bag, the nurse I had been speaking with lingered in the room. I sensed she wanted to ask me something.

Sure enough, she soon 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 did not notice it right away, but her eyes were beginning to water behind her glasses. “Yes . . . before I came here.”

“Was this something that motivated you to work in the hospice?”

“Yes . . . ” She paused. It 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 a 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 wasn’t sure how. I reached down and picked up the paper cup I had left on the table. It was still full of lukewarm 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 to not 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 experience with a patient, but the moment to let her share this story was now gone. The rain sprinkled down on me as I walked to the train station, but I didn’t care. It felt appropriate. There was a gnawing sensation in my stomach. I knew that I would be haunted for a long time by the sight of her eyes brimming with tears that were filled with a deep pain.

This was not the first time during my fieldwork that a nurse or doctor began to tear up 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 an interview that she felt relieved and healed by sharing her memories of past patients. But I knew that I was only scratching the surface. Just like patients were constrained in sharing their concerns with hospice workers, hospice workers were constrained in speaking with me. Their stories about past patients were also stories about their own deep experiences of loss.

I begin this final chapter 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] Paul Gauguin puts it more eloquently in his 1898 masterpiece *D’où venons-nous ? Que sommes-nous ? Où allons-nous ?* (Where Do We Come From? What Are We? Where Are We Going?).[2]

Gaugin wished this painting to be his swansong. In 1897, Gauguin received word of the death of his daughter. Struggling with this news, he poured his energy into the large painting (measuring 139.1 cm × 374.6 cm), which he later claimed to be his best work and a summation of all his ideas. After completing the painting, he then unsuccessfully tried to commit suicide.[3]

The painting depicts a number of figures at different stages of life. As Gauguin later explained in a letter:

> To the right at the lower end, a sleeping child and three crouching women. Two figures dressed in purple confide their thoughts to one other. An enormous crouching figure, out of all proportion, and intentionally so, raises its arms and stares in

FIGURE 11. Paul Gauguin, *Where Do We Come From? What Are We? Where Are We Going?* (1898). Photograph © 2023 Museum of Fine Arts, Boston.

> astonishment upon these two, who dare to think of their destiny. A figure in the centre is picking fruit. Two cats near a child. A white goat. An idol, its arms mysteriously raised in a sort of rhythm, seems to indicate the Beyond. Then lastly, an old woman nearing death appears to accept everything, to resign herself to her thoughts. She completes the story! At her feet a strange white bird, holding a lizard in its claws, represents the futility of words.[4]

Sometimes we need art when words fail. Gauguin's painting poses a diachronic narrative, but it also synchronically captures everything at once. Birth and death are juxtaposed, as well as the tension between this world and the Beyond. Finally, the viewer's eyes are drawn to the "strange white bird" in the lower corner, which mutely expresses the futility of finding a clear answer to the questions Gauguin poses in the upper left corner of the canvas. According to one hospice chaplain I met in Japan, this painting deeply resonated with the dying patients he showed it to. As the phrase, "my life flashed before my eyes" conveys, imminent death can juxtapose a medley of memories and feelings that can be difficult to put into words. Gauguin's "strange white bird" reminds us that sometimes there are also wordless gaps in ethnography that are not meant to be filled. This is where art comes in. Great artists can create works where even opposites are coherently contained in the same space.[5] Unfortunately, I am no artist. In these last pages, however, I will try to compensate for these failings by reviewing some of the main themes from this study in my own rough, broad strokes.

THE "HEART" OF JAPANESE RELIGION

At the beginning of this book, I posed a question: since most Japanese pray at a Shinto shrine, get married in a Christian chapel, lead a secular life, and have a Buddhist funeral, what role does religion play at the end of life? The question of how religious beliefs and practices connect in contemporary Japan's mostly secular society has been something of a puzzle for scholars of Japanese religions for some time. Yet sometimes the puzzle is only in the eye of the beholder. For example, after hearing this saying for the first time, one of my Japanese university students was intrigued. She told me, "I had never thought of that." In other words, the common Japanese religious or nonreligious disposition only becomes a puzzle when it is transposed into a question that identifies distinctive modes of religious belief and practice. For many "nonreligious" Japanese who still take part in such religious activities, there is no puzzle at all. Rather, religion organizes life in Japan in subtle ways.[6] It rings in the New Year, it sets the schedule for summer vacation, and it presides over many of life's most important transitions. It is unconsciously omnipresent and yet consciously remote at the same time. None of this is typically felt as a contradiction for those who participate in it.

This puzzle plays out in a similar way in hospice care as well. For some hospice patients, religion not only organizes their life, but also helps them transcend or overcome deep-held anxieties in the face of death. Such patients provide a particularly important rationale for legitimizing the religious work of chaplains, who sometimes struggle to articulate their role in the hospice to other medical workers. Patients who openly find comfort through religious support also offer chaplains validation of their suspicion that perhaps other patients may have latent or repressed religious concerns that require care.

But most hospice patients rarely talk about religion at all. Patients are far more likely to express anxiety about being a burden on their family and dismiss existential concerns that "cannot be helped." In practice, chaplains and other hospice staff usually conduct a type of spiritual care that eschews explicitly religious support in favor of helping patients "be themselves" by supporting the *kokoro* of patients in relatively pedestrian—but still meaningful—activities and through the maintenance of relationships that help the patients feel valued and appreciated at the end of life. This is not to deny that patients who self-identify as not religious necessarily fail to appreciate religious care. Many such patients told me about how much they enjoyed listening to the Buddhist sermons or listening to hymns that reminded them of the Christian schools they had attended in their youth, or of celebrating various religious holidays in the hospice. Such comments reinforce the conclusions drawn by Jesse LeFebvre in his study of Christian wedding ceremonies in Japan, where he argues that most Japanese simply define themselves as "not religious" (*mushūkyō*) to signal their distance from religious behaviors that are considered "deviant, atypical, or extraordinary." What most Japanese mean when they say they are "not religious" is merely that they are not cognitively committed to any one particular religious tradition; nonetheless, they may still participate in a variety of religious activities with affective sincerity and often do so through the work of religious professionals who offer an eclectic range of religious services to them.[7]

The importance of the affective dimensions of religious practice in Japanese society also helps explain why spiritual care is often centered on supporting the *kokoro* of patients. The *kokoro* serves as the seat of feelings, but it also symbolizes the mind and the self. Kawaii Hayao, who introduced Jungian psychotherapy in Japan, famously described this reluctance to identify with one religion as the "empty center" (*chūkū kōzō*) that lies in the *kokoro* of many Japanese persons.[8] While Kawaii is prone to overstate the uniqueness of the Japanese psyche in ways that calls for cautious analysis, there is something to be said for the explanatory power of the image of an open *kokoro* that is circumscribed by occasional participation in and affective appreciation for a broad range of religious practices. In such ways, the puzzle of religion at the deathbed in Japan challenges the penchant to measure Japanese religious identity or affiliation in terms of belief and practice and demonstrates the need for more analysis of the role that feelings play in the forming of Japanese religious and nonreligious identities.[9]

RETHINKING SPIRITUALITY AT THE END OF LIFE

This study has also sought to cast a critical eye on the concept of spirituality as it is employed in academic and clinical scholarship on Japanese hospice care. Namely, I have shown how the term "spirituality" serves to negotiate the flexible boundaries between religion and the secular to legitimize and valorize the role Japanese religious workers play in the hospice. Scholarly and clinical debates over definitions of spirituality in Japan show how spirituality and spiritual care are defined in ways that different stakeholders can sanction or prohibit the acceptable parameters of religious care for patients. In other words, the spiritual is best understood as a strategic 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 nonreligious ways. The semantic ambiguities in the term "spirituality" have also created 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 these definitional enterprises has been a reification and medicalization of the concept of spirituality that draws lines between it and the physical and psychosocial dimensions of hospice care. 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 turning chaplains into experts who are qualified to treat the pain emanating from a patient's spirituality. But this also calls into question whether the emphasis on the etiology of spiritual pain also undermines the very original ethos of hospice care; namely, Saunders's original call to simply treat the patient as a whole person.

By focusing on the way lines are drawn differently between spiritual and religious, this study shows some of the ways that more religious forms of care in hospice settings are either marginalized or camouflaged in practice. For instance, 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 what Wendy Cadge calls a "strategically vague frame" that makes their work more palatable to patients, the patient families, and other medical staff members. This vague frame also occasionally creates confusion over how the chaplain's work might differ from that of a clinical psychologist. Many chaplains defend their work to medical colleagues who are confused about the chaplain's role by framing 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. To justify their work, chaplains cite cases of patients who report the value of having found something they could hold on to as they approach the end of life. Although such patients are in fact few, they are important for chaplains to show that their religious training can be of aid in practicing spiritual care. In this way, the ambiguous term “spiritual” can be used to both prohibit and sanction the role religion plays in Japanese hospice care.

SPIRITUAL CARE AS A GLOBAL CONVERSATION

Another key theme of this study is that spiritual care in Japan is part of a global conversation. For instance, North American and European medical missionaries played a prominent role in helping establish Christian hospitals in Japan that later served as training grounds and influential centers for the development of models of spiritual care. Their efforts eventually spurred Buddhists to develop their own vision for hospice care through the Vihāra movement. The application of spirituality as a clinical term in Japan has also 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 Britain, 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 South 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. Larger hospitals like Yodogawa Christian Hospital also have regular exchanges with Christian “sister hospitals” in South Korea and Taiwan. Likewise, Japanese Buddhist groups have traveled to Taiwan where Buddhists are active in providing spiritual care to hospice patients, including at the National Taiwan University Hospital.[10] In 2016, the Rinbutsuken Institute for Engaged Buddhism in Tokyo held 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.

The global conversations between spiritual care practitioners help remind us of the important influence of globalization on Japanese religions.[11] The introduction of spiritual care to 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.[12] Spiritual care is embedded in global discourses on the definition and practice of spiritual care and simultaneously assuming new forms in local spaces. This local context is essential to avoid portraying spiritual care as simply a foreign import to Japan. Instead, hospice workers have been active in defining and interpreting models of spiritual care in ways that reflect the particularities of the Japanese cultural and religious context. That context includes unfamiliarity on the part of patients and hospice workers about what spiritual care actually means; the large population of hospice patients who describe themselves as not religious; and a society-wide suspicion toward the work of religious professionals in general, let alone in delicate spaces like hospices. As a result, although hospice workers are conscious of the models of spiritual care found in English-language hospice-care literature that presume the regular practice of sacramental care for religious patients or existential counsel to help find meaning at the end of life, in practice, their work follows a model that is more diffuse and supportive of the *kokoro*. That is to say, they often see spiritual care as occurring in the margins of mundane interactions or activities that help patients feel valued, often without even mentioning religion.

By framing these exchanges and negotiations between Japanese and non-Japanese ideas 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 show how spiritual care in Japan is part of a series of cross-cultural interactions. While Christian discourses from Europe and North America have certainly played a strong role in impacting the practice of spiritual care in Japan, this impact was by no means a one-way street. For example, long before the concept of spiritual care was introduced to Japan, Japanese religious scholars like D. T. Suzuki had already played an indirect role in shaping models of spiritual care outside of Japan through his dialogue with leading figures in humanistic psychology like Eric Fromm and Carl Jung. Similarly, while Japan may be unique in some of the ways that spiritual care is practiced, this study has showed that the "heart" of spiritual care in Japan is far from invariable. Rather, it is dynamic and changing. In order to avoid these pitfalls, I have endeavored to describe spiritual care as a series of interactions, which Nicolas Standaert proposes "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."[13] In this way, the development of spiritual care in Japan can be seen as a series of ongoing interactions between Japan and other cultural settings 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.

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 study 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. For example, 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 to provide charitable medical care to the destitute and needy. By the end of the twentieth century, however, Buddhist and Christian groups were largely cooperating 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, especially in care for the dying. Religious involvement in hospice care also led to the establishment of several interfaith spiritual care training programs. These ecumenical interactions show that clinical models of spiritual care do not necessarily break down along religious lines. Some Buddhists and Christians agree on the extent to which religion should play a role in spiritual care or on how to define spirituality; others, meanwhile, disagree. This shows how 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 many Buddhists trace their hospice care expertise to the premodern practice of *rinjū gyōgi* rites in which Buddhist adepts helped the dying achieve right-mindfulness at death, the connections between these two forms of care are mostly rhetorical. In practice, contemporary spiritual care is framed in inclusive psychotherapeutic language rather than through traditional soteriological terms that have denominational inflections.

FINAL WORDS

Religion in contemporary Japan is both shaping and being shaped by care for the dying in modern medical spaces. In the field of hospice care, definitions of spiritual care are marked by important tensions between the demarcation of the religious and the secular, ideals and practice, the needs of patients and the needs of hospice workers, and the assumed presence of spiritual pain in terminal patients and denials by patients about such concerns. 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. Sometimes in ethnography, linguistic communication "flattens rather than evokes phenomena."[14] I, too, felt this "flattening" of the patients' experiences as they entered my field notes. The tensions and conflicting accounts that I gathered from hospice workers and patients begged for a new frame to put them in relation with each other—to account for differences and silences in their stories. I wish I could paint like Paul Gauguin, but, perhaps, some things just "can't be helped."

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At the end of life, some hospice patients take part in what is called a "life review." They look back over their life with an eye to thanking family and close friends. I, too, have incurred many intellectual and personal debts in writing this book for which I would like to give thanks.

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Finally, this book would never have been possible but for the unflagging support and sacrifices made by my family. My parents, if I remember correctly, never failed to order whatever book I wanted to read while growing up in the back mountains of Japan. I am so grateful for their support of all my academic adventures over the years. My parents-in-law and sister-in-law also provided a refuge of good food, babysitting, temporary housing, and moral support at various times during my research. My three lovely children, Emily, Theo, and Elena, helped keep me sane. If I ever needed to stop thinking about this book, their energetic and lively antics night and day never failed to clear my mind of anything remotely related to death.

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NOTES

PREFACE

1. "Religious identity" continues to be a fraught term in Japan (and elsewhere), where individual religious practices and beliefs are not always exclusive to one type of religion. Anna Sun helpfully distinguishes between explicit and implicit forms of religious identity. By explicit religious identity she refers to the "self-avowed identification of individuals with a specific religious tradition," while implicit religious identity refers to "people who practice various religious rituals, beliefs, and ethics that are significant or even central to their identity and conception of a meaningful life, yet they do not necessarily acknowledge it as the source of a religious identity for cultural, historical, social, or political reasons." This study considers both types, but especially implicit religious identity, which is more prevalent in Japan. Anna Sun, "To Be or Not to Be a Confucian: Explicit and Implicit Religious Identities in the Global Twenty-First Century," *Annual Review of the Sociology of Religion* 11 (2021): 216.

1. SOUL SEARCHING IN THE JAPANESE HOSPICE

1. Cicely Saunders, "Spiritual Pain," *Contact*, no. 122 (October 1991): 7.

2. Christina M. Puchalski et al., "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus," *Journal of Palliative Medicine* 17, no. 6 (2014): 642–56.

3. Christopher Swift, *Hospital Chaplaincy in the Twenty-first Century, 2nd Edition: The Crisis of Spiritual Care on the NHS* (London: Routledge, 2016), 148.

4. Winnifred Fallers Sullivan, *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014).

5. An important English-language exception is Susan Orpett Long's study of end-of-life care in Japan, which remains one of the few extended ethnographic treatments of this subject. Long pays particular attention to the role of 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 also conducted in the 1990s, when hospice care in Japan was still finding its feet and attention to spiritual care was not yet widespread. Susan Orpett Long, *Final Days: Japanese Culture and Choice at the End of Life* (Honolulu: University of Hawai'i Press, 2005). See also "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. Another ethnographic study in Japanese is an unpublished dissertation by Arita Megumi, who conducted 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 interviews 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.

6. Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012), 101.

7. Ishii Kenji, *Dētābukku: Gendai Nihonjin no shūkyō* (Tokyo: Shinyōsha, 2007), 2, 21.

8. 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.

9. 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.? Nonsense! 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.

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

11. "Kōreisha no jinkō," Statistics Bureau of Japan, accessed September 9, 2021, www.stat.go.jp/data/topics/topi971.html.

12. "Population Projections for Japan (2017): 2016 to 2065," National Institute of Population and Social Security Research, accessed May 29, 2020, www.ipss.go.jp/pp-zenkoku/e/zenkoku_e2017/pp29_summary.pdf.

13. Ibid., 1.

14. Timothy O. Benedict, "Death in Modern Japan (1800–2020)," in *The Routledge History of Death Since 1800*, ed. Peter N. Sterns (Oxon: Routledge, 2021).

15. 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*, ed. Kumagai Sonoko and Ōkubo Takaji (Tokyo: Nihon Kazoku Shakai Gakkai Zenkoku Kazoku Chōsa Iinkai, 2005), 139–54; "The Japanese Family System: Change Continuity, and Regionality over the Twentieth Century," Max Planck Institute for Demographic Research (March 2013), accessed September 21, 2017, www.demogr.mpg.de/papers/working/wp-2013–004.pdf.

16. Hirayama Hideyuki, Masukawa Kento, and Miyashita Mitsunori, "Dētā de miru Nihon no kanwa kea no genjō," in *Hosupisu kanwa kea hakusho 2021*, ed. Kizawa Yoshiyuki et al. (Tokyo: Sekaisha, 2020), 68.

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

18. On 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 tāminaru kea," in *Gendai iryō no shakaigaku: Nihon no genjō to kadai*, ed. Kuroda Kōichirō (Kyoto: Sekai shisōsha, 1995), 245–62.

19. Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York: Oxford University Press, 1999).

20. Hirayama, Masukawa, and Miyashita, "Dētā de miru," 56–59.

21. In Japan's CiNii article database, the number of search hits for "palliative care" in the period from 1984 to 2021 outnumber "hospice" 9,429 to 2,641. However, in the *Asahi* newspaper database, the number of articles that mention "hospice" in that same period outnumber "palliative care" 4,392 to 3,027 (September 26, 2021). Hospice care is sometimes also referred to as "terminal care" (*tāminaru kea*), but this has largely fallen out of favor.

22. Hirayama, Masukawa, and Miyashita, "Dētā de miru," 59–62.

23. Tamiya Masashi, who chose this Sanskrit term, followed (perhaps unconsciously) a long-standing Buddhist tradition that legitimates "new" practices by looking back to India. Nihon Bukkyō Shakai Fukushi Gakkai, ed., "Vihāra," in *Bukkyō shakai fukushi jiten* (Kyoto: Hōzōkan, 2006), 254–55; Robert E. Buswell Jr. and Donald S. Lopez Jr., eds., *Princeton Dictionary of Buddhism* (Princeton, NJ: Princeton University Press, 2014), 968.

24. The most comprehensive account of chaplaincy training programs in Japan thus far is Fujiyama Midori's *Rinshō shūkyōshi: Shi no bansōsha* (Tokyo: Kōbunken, 2020). I have largely excluded detailed discussion of spiritual care training programs and education from this study since the details surrounding the establishment and curriculum of chaplaincy training programs in Japan have begun to receive increased attention. For more on spiritual care education, see Nathaniel Michon, "Awakening to Care: Formation of Japanese Buddhist Chaplaincy," (PhD diss, Graduate Theological Union, 2020); and Kenta Kasai, "Introducing Chaplaincy to Japanese Society: A Religious Practice in Public Space," *Journal of Religion in Japan* 5, no. 2–3 (2016): 246–62.

25. Murase Masaaki et al., "Kanwa kea byōtō ni okeru shūkyōka no katsudō no genjō ni tsuite no shitsuteki kenkyū," Japan Hospice Palliative Care Foundation, accessed April 10, 2018, www.hospat.org/assets/templates/hospat/pdf/report_2012/2012-c1.pdf.

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

27. "Kanwa kea byōto nyūin todokede-jurishisetsu," accessed May 8, 2017, www.hpcj.org/list/relist.php.

28. Walter Principe, "Toward Defining Spirituality," *Studies in Religion* 12, no. 2 (1983): 127–41.

29. Leigh Eric Schmidt, *Restless Souls: The Making of American Spirituality* (San Francisco: Harper San Francisco, 2005), 2–5.

30. Courtney Bender, *The New Metaphysicals: Spirituality and the American Religious Imagination* (Chicago: University of Chicago Press, 2010), 182.

31. Jonathan R. Herman, "The Spiritual Illusion: Constructive Steps Towards Rectification and Redescription," *Method and Theory in the Study of Religion* 26 (2014): 159–82.

32. 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.

33. 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): 258–78.

34. Herman, "The Spiritual Illusion," 162–63.

35. Ibid., 171.

36. For more on these problems, see Horie, "Spirituality and the Spiritual: Translation and Transformation," *Journal of Alternative Spiritualities and New Age Studies* 5 (2009), www.asanas.org.uk/files/005Horie.pdf (accessed August 31, 2013); 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), 267–85; Craig Martin, *Capitalizing Religion: Ideology and the Opiate of the Bourgeoisie*, (London: Bloomsbury, 2014), 62–63; and Kerry A. Mitchell, "The Politics of Spirituality: Liberalizing the Definition of Religion," in *Secularism and Religion Making*, ed. Markus Dressler and Arvind-Pal S. Mandair (Oxford: Oxford University Press, 2011), 126.

37. 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 nonreligious readers to use the opportunity of learning about "spirituality" to rethink their understanding of themselves as "outside" religion. *Gendai shūkyō to supirichuariti* (Tokyo: Kōbundō, 2012), 140, 7. Likewise, Kashio Naoki, another scholar of religion, 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. "Supirichuariti to wa nani ka? Gendai bunka no reiseiteki shosō," in *Bunka to reisei*, ed. Kashio Naoki (Tokyo: Keio Gijuku Daigaku Shuppan, 2012), 3. Kashio 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]). Hayashi Yoshihiro, a scholar of philosophy and religion, also expresses his hope that spirituality will serve the members of Japanese society whose

hearts have "lost their bearings." *Toi to shite no supirichuariti: "Shūkyō naki jidai" ni seishi o kataru* (Kyoto: Kyoto Daigaku Gakujutsu Shuppankai, 2011), iii.

38. Jolyon Baraka Thomas, *Faking Liberties: Religious Freedom in American-Occupied Japan* (Chicago: University of Chicago Press, 2019), 246.

39. Eric M. Stephen, "Bringing Reflexive Religious Studies into Historical Scholarship on American Religion," *American Religion, Inside Out*, accessed August 25, 2021, www.american-religion.org/inside-out/stephen.

40. Jacqueline I. Stone, *Right Thoughts at the Last Moment: Buddhism and Deathbed Practices in Early Medieval Japan* (Honolulu: University of Hawai'i Press, 2016), 381.

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

42. Michael Burawoy, "The Extended Case Method," in *Ethnography Unbound: Power and Resistance in the Modern Metropolis*, ed. Michael Burawoy et al. (Berkeley: University of California Press, 1991), 281.

43. Margarete Sandelowski, "Whatever Happened to Qualitative Description?" *Research in Nursing and Health* 23, no. 4 (2000): 336.

2. THE RHYTHMS OF HOSPICE CARE

1. For example, the Japanese title of Natsume Soeseki's famous novel *Kokoro* (1914) was left intact in its English translation.

2. Helen Hardacre, *Kurozumikyō and the New Religions of Japan* (Princeton, NJ: Princeton University Press, 1986), 18–21.

3. Adam Lyons, *Karma and Punishment: Prison Chaplaincy in Japan* (Cambridge, MA: Harvard University Asia Center Press, 2021).

4. Norichika Horii, *The Category of "Religion" in Contemporary Japan: Shūkyō and Temple Buddhism* (Cham, Switzerland: Palgrave Macmillan, 2018), 96.

5. 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 Hawai'i, 2015).

6. Kashiwagi Tetsuo, *Teihon hosupisu, kanwa kea* (Tokyo: Seikaisha, 2006), 38–39.

7. For more on the use of sedation for patients with spiritual pain, see Tatsuya Morita, "Palliative Sedation to Relieve Psycho-Existential Suffering of Terminally Ill Cancer Patients," *Journal of Pain and Symptom Management* 28, no. 5 (November 2004): 445–50.

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

9. Personal interview, January 30, 2015.

10. Personal interview, January 21, 2015.

11. Personal interview, January 22, 2015.

12. *Asahi Shimbun*, "Makki kanja o dakishimeru," May 28, 1985; *Asahi Shimbun*, "Bukkyō hosupisu no jitsugen o," October 27, 1986.

13. Giving the dying water is also a ritual of parting between the family and the dying person that goes back to medieval times. It is now often symbolically reenacted during the funeral, but the rite may have arisen from the custom of moistening the mouth to facilitate the continuous chanting of the Buddha's name (*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*, ed. Jacqueline I. Stone and Mariko Namba Walter (Honolulu: University of Hawai'i Press, 2008), 76.

14. 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. 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.

3. THE HEART OF PRACTICING SPIRITUAL CARE

1. Personal interview, January 22, 2015.

2. Personal interview, February 2, 2015.

3. Since the role of the bodhisattva is to take on the sufferings of all beings, a bodhisattva image was seen as more appropriate for the hospice.

4. Baba, Hanaoka, and Tsukie, "Shūmatsu iryō no naka."

5. 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.

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

7. Personal interview, March 25, 2015; personal interview, May 5, 2015.

8. Hayashi Moichiro, "'True Regard': Shifting to the Patient's Standpoint of Suffering in a Buddhist Hospital," in *Buddhist Care for the Dying and Bereaved*, ed. Jonathan S. Watts and Yoshiharu Tomatsu (Boston: Wisdom Publications, 2012), 63.

9. 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.

10. Hirayama, Masukawa, and Miyashita, "Dētā de miru," 59.

11. Japan Hospice Palliative Care, "Hosupisu kanwa kea ni kansuru ishiki chōsa (2006–2012)," www.hospat.org/research-top.html (accessed March 31, 2017).

12. Baffelli and Reader, "Impact and Ramifications," 8.

13. Isaac Gagné, "Religious Globalization and Reflexive Secularization in a Japanese New Religion," *Japan Review* (2017): 153–77.

14. Tanida Noritoshi, "Supirichuaru kea: Komyunikeishon kara no tenkai," in *Taiwa, komyunikeishon kara manabu supirichuaru kea: Kotoba to monogatari no jissen*, ed. Tanida Noritoshi, Ōshita Daien, Itō Takaaki (Tokyo: Shindan to Chiryōsha, 2011), 9.

15. Hanaoka Naoki, "Sei to shi no imi o sasaeru: Shūkyōteki ni kakawatta 3 jirei," *Kanwa kea* 22, no. 3 (2012): 229–32.

16. Shinran (1173–1263) was the founder of the Shin Buddhist sect.

17. Personal interview, January 29, 2015.

18. 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.

19. Personal interview, June 11, 2015.

20. Personal interview, May 21, 2015.

21. Andō Yasunori, "'Supirichuariti' gainen no saikō: Supirichuariti wa reiteki sekaikan o zentei to suruka?" *Shiseigaku nenpō* 4 (March 2008): 19.

22. Long, *Final Days*, 62–63.

23. Even if they are not used, these religious spaces establish a certain atmosphere. For example, Nakahara Toyoko utilized James Gibson's work on "affordances" to discuss how the physical features of the hospice were designed to "afford" patients spiritual care. Thus, an empty chair facing the Buddhist altar might invite or afford the patient an opportunity to pray even if they do not actually use it. Nakahara, "Gan kanja ga bihāra ni nyūin shi byōtō to iu kyōdōtai no kōseiin ni naru katei" (paper presented at the Bukkyō Kango Bihāra Gakkai, Higashi Betsuin Temple, Kanazawa, Japan, August 30, 2015).

24. A chaplain at a Protestant hospice in Kyūshū also echoed this description of spiritual care. He explained that the design of hospice facilities, small talk with patients, and various events and activities all functioned as a form of "spiritual support." Kiyota Naoto, "Hosupisu kanwa kea ni okeru supirichuaru kea no teigi" (paper presented at the Nihon Supirichuaru Kea Gakkai Gakujutsutaikai, Kōyasan University, Wakayama, Japan, September 12, 2015).

25. Personal interview, June 8, 2015.

26. Timothy O. Benedict, "Practicing Spiritual Care in the Japanese Hospice," *Japanese Journal of Religious Studies* 45, no.1 (2018): 188.

27. Robert Orsi, "Everyday Miracles: The Study of Lived Religion," in *Lived Religion in America*, ed. David D. Hall (Princeton, NJ: Princeton University Press, 1997), 7.

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

62–63.

29. Personal interview, June 25, 2015.

30. This point is reiterated by Nishino Hiroshi, "Rinshōi no naratibu: Mizu kara no supirichuaru pein to mukiatte," in *Supirichuaru pein ni mukiau: Kokoro no annei 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 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), 83.

31. 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 Shuppankai, 2011), 42.

32. Personal interview, July 2, 2015.

33. Kubotera Toshiyuki, "Supirichuaru pein no honshitsu to kea no hōhō," *Kanwa kea* 15, no. 5 (2005): 392.

34. 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.

35. John Traphagan, *The Practice of Concern: Ritual, Well-Being, and Aging in Rural Japan* (Durham, NC: Carolina Academic Press, 2004), 177; Ian Reader, *Religion in Contemporary Japan* (Honolulu: University of Hawai‘i Press, 1991) 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.

4. THE MEANING OF SPIRITUAL PAIN

1. Nakano Kōji, *Gan nikki: Nisen yonen nigatsu yōka yori sangatsu jūhachinichi nyūin made* (Tokyo: Bungei Shunjū, 2006), 83.

2. Gordon Mathews, *What Makes Life Worth Living? How Japanese and Americans Make Sense of Their Worlds* (Berkeley: University of California Press, 1996).

3. Saunders, “Spiritual Pain,” 6–7.

4. Toshimaro Ama, *Why Are the Japanese Non-Religious? Japanese Spirituality: Being Non-Religious in a Religious Culture* (Lanham, MD: University Press of America, 2005).

5. All but 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 initially planned to speak with several dozen patients, at this particular hospice I was only able to interview eight. The lengths of interviews averaged between twenty to thirty minutes. The shortest was 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 nonreligious hospices from 2014 through 2015 and the summers of 2012, 2013, and 2017. I have included one of those patients (Mizuno-san) in this chapter.

6. See Mark Rowe, *Bonds of the Dead: Temples, Burial, and the Transformation of Contemporary Japanese Buddhism* (Chicago: University of Chicago Press, 2011).

7. Long, *Final Days*, esp. chap. 4; also Fleur Woss, “Pokkuri Temples and Aging,” in *Religion and Society in Modern Japan*, ed. Mark R. Mullins et al. (Berkeley: Asian Humanities Press, 1993), 191–202.

8. 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.

9. 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): 110–18. For studies on the self-perceived burden in Japanese patients, see Timothy Benedict, “Meiwaku o kaketakunai hosupisu kanja to supirichuaru kea,” *Supirichuaru kea kenkyū* 3 (2019): 43–53; 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): 224–34; 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): 145–52.

10. Masako Kawa et al., "Distress of Inpatients with Terminal Cancer in Japanese Palliative Care Units: From the Viewpoint of Spirituality," *Supportive Care in Cancer* 11 (2003): 485.

11. FACIT Group, "FACIT-Sp-12," accessed January 8, 2021, www.facit.org/measures/FACIT-Sp-12.

12. 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.

13. In general, as many chaplains explained to me, most patients are reluctant to discuss religious questions they might have. In a 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." Kawa et al., "Distress of Inpatients," 488. Similar results were also found in a 2006 survey on what constituted a good death. Researchers found that of thirteen hospice patients surveyed, only two responded that having faith was important for a good death. 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.

14. Personal interview, May 18, 2015.

15. Personal interview, March 25, 2015.

16. Personal interview, May 5, 2015.

17. Personal interview, May 7, 2013.

18. Nakamura Hajime, *Kōseitsu bukkyōgo daijiten* (Tokyo: Tokyo Shoseki Kabushikigaisha, 2001), 1106.

19. Saunders, "Spiritual Pain," 6–7. 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): 378–85.

20. Morita et al., "Existential Concerns," 139.

21. Jonathan Jong and Jamin Halberstadt, *Death Anxiety and Religious Belief: An Existential Psychology of Religion* (New York: Bloomsbury, 2016), 105. See also Herman Feifel and Allan B. Branscomb, "Who's Afraid of Death?" *Journal of Abnormal Psychology* 81, no. 3 (1973): 282–88.

22. 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): 353–60.

23. Jong and Halberstadt, *Death Anxiety*, 104–5. Terror-management theory 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. Jong and Halberstadt, *Death Anxiety*, 40.

24. This echoes several 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): 203–17.

25. This is reminiscent of the story Doi Takeo tells in the opening to *The Anatomy of Dependence*. Doi is pressed by his American host to accept some ice cream, but after politely refusing at first, he is disappointed when they don't offer it again. Doi uses this story and others to introduce how *amae* (dependence) governs Japanese social relations. *The Anatomy of Dependence*, trans. John Bester (Tokyo: Kodansha International, 1981), 11.

26. Personal interview, March 25, 2015.

27. Tenrikyō is a religion that was founded in the mid-nineteenth century by Nakayama Miki (1798–1887).

28. Personal interview, May 21, 2015.

29. Personal interview, May 18, 2015.

30. Hoshino Tomihiro (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 resiliency of the human spirit.

31. Wendy Cadge, *Paging God*, 195.

32. Kashiwagi, "Yamu hito no tamashii," 42.

33. Isaac Gagné, "Private Religion and Public Morality: Understanding Cultural Secularism in Late Capitalist Japan" (PhD diss., Yale University, 2003), abstract. This is also evocative of the term "areligious secularism," which W. Clark Gilpin employs to describe individuals who tell "secular stories of their lives that incorporate elements derived [from] 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.

34. Christian chapel weddings are very popular in Japan and account for approximately 60 to 70% of wedding ceremonies in the Tokyo area. Jesse LeFebvre, "Christian Wedding Ceremonies: 'Nonreligiousness' in Contemporary Japan," *Japanese Journal of Religious Studies* 42, no. 2 (2015): 192.

35. Personal interview, March 25, 2015.

36. Personal interview, May 21, 2015.

5. THE INVENTION OF JAPANESE SPIRITUALITY

1. 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.

2. By invoking the "invention" of spirituality, I am consciously drawing on Jason Ānanda Josephson's study, *The Invention of Religion in Japan* (2012). As Josephson reminds us, the provenance of "religion" (*shūkyō*) as a concept in Japan is quite recent. The term only 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. *The Invention of Religion in Japan* (Chicago: University of Chicago Press, 2012).

3. *Suzuki Daisetsu zennshū*, vol. 29 (Tokyo: Iwanami, 1970), 409; Suzuki Daisetz, *Japanese Spirituality*, trans. Norman Waddell (Tokyo: Yushodo, 1972), 24.

4. Dietrich Bonhoeffer (1906–1945) also invoked a similar term, "religionless Christianity" (*religionsloses Christentum*), which Kelly and Nelson explain 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 [religion's] more Westernized, self-serving constrictions and emphasis on inward piety and empty rituals." Geffrey B. Kelly and F. Burton Nelson, *A Testament to Freedom: The Essential Writings of Dietrich Bonhoeffer* (San Francisco: Harper San Francisco, 1995), 547–48.

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

6. Suzuki, *Japanese Spirituality*, 14–15.

7. Ibid., 15.

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

9. Ibid., 264.

10. 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): 175–99.

11. Jung wrote the foreword to Suzuki's *Introduction to Zen Buddhism* (1939). Fromm, Suzuki, and Richard De Martino also coauthored a book titled *Zen and Psychoanalysis* (1970).

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

13. Tomoe Moriya, "D. T. Suzuki at the World Congress of Faiths in 1936: An Analysis of His Presentation at the Interfaith Conference," *Journal of Religion in Japan* 10, nos. 2–3 (July 14, 2021): 135–60. https://doi.org/10.1163/22118349–01002001.

14. It was, however, occasionally used in Christian theological texts as a translation for the English word "spiritual." Horie Norichika, "Reisei kara supirichuariti e," *Kokusai Shūkyō Kenkyūjo nyūsuretā* 38 (April 2003): 14–22.

15. Shimazono Susumu, *Supirichuariti no kōryū: Shinreisei bunka to sono shūhen* (Tokyo: Iwanami Shoten, 2007), 5; *Seishin shakai no yukue: Shūkyō, kindai, reisei* (Tokyo: Akiyama Shoten, 2007); *From Salvation to Spirituality: Popular Religious Movements in Modern Japan* (Melbourne: Trans Pacific Press, 2004); and Shimazono and Graf, "The Rise of the New Spirituality," in *Handbook of Contemporary Japanese Religions*, ed. Inken Prohl and John Nelson, 459–85 (Leiden: Brill, 2012).

16. Shimazono and Graf, "The Rise of the New Spirituality," 460.

17. Shimazono, *Seishin shakai*, 4.

18. Erica Baffelli and Ian Reader, "*Dynamism and the Ageing of a Japanese 'New' Religion: Transformations and the Founder*" (London: Bloomsbury Academic, 2019), 55.

19. Horie Norichika, "Spirituality and the Spiritual in Japan."

20. Ioannis Gaitandis, "Spiritual Therapies in Japan," *Japanese Journal of Religious Studies* 39 (2005): 357–58.

21. For an overview of broader shifts in how the word "spirituality" was used and understood in Japanese popular culture, see Horie Norichika, *Poppu supirichuariti: Mediaka sareta shūkyōsei* (Tokyo: Iwanami, 2019).

22. Ehara Hiroyuki, *Jibun no tame no "reigaku" no susume: Ningen o migaki, reisei o migaku* (Tokyo: Hāto Shuppan, 1994); *Shinrei baiburu* (Tokyo: Magajin Hausu, 1995).

23. 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): 375–97.

24. Quoted in Andō "'Supirichuariti' gainen," 14.

25. Shimazono, *Seishin shakai*, 243–53.

26. Horie, *Poppu supirichuariti: Mediaka sareta shūkyōsei*, 25; Kasai Kenta and Itai Masanari, eds., *Kea to shite no shūkyō* (Tokyo: Akashi Shoten, 2013).

27. Koyabu Tomoko et al., "Supirichuariti no ninchi to umu to kotoba no imeiji: 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.

28. 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.

29. Christine Puchalski, "Restorative Medicine," in *Oxford Textbook of Spirituality in Healthcare*, ed. Mark Cobb, Christina M. Puchalski, and Bruce Rumbold (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): 1183–88.

30. Christina Puchalski, "The Role of Spirituality in Healthcare," *Proceedings (Baylor University, Medical Center)* 14, no. 4 (2001): 352–57.

31. Center for Medicare and Medicaid Services, "Medicare and Medicaid: Hospice Conditions of Participation," *Federal Register* 5, no. 73 (2008): 32167–68.

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

33. Ibid., 180.

34. Ibid., 218; "Facing Death," *The Way* (October 1984): 301; Saunders, "Spiritual Pain," 6–9.

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

36. Saunders, "Facing Death," 302–3.

37. Saunders, *Selected Writings,* 226.

38. Cicely Saunders, "A Personal Therapeutic Journey," *British Medical Journal* 313, no. 7072 (1996): 1600.

39. World Health Organization, "WHO Definition of Palliative Care," accessed May 24, 2016. www.who.int/cancer/palliative/definition/en.

40. For example, see Tanida, "Supirichuaru kea," 2.

41. World Health Organization, "WHO Definition of Health," accessed May 4, 2012. www.who.int/about/definition/en/print.html. Emphasis mine.

42. Kasai Kenta traces the source of this interest to a news article published in the *Nihon Keizai Shinbun* in February of 1999. Kasai Kenta, "WHO ga 'spirituality' gainen no

hyōjunka o motometa kei ni tsuite," *Kokusai shūkyō kenkyūjo nyūsuretā* 38 (March 2003), accessed March 11, 2016, www.circam.jp/files/user/activities/download/02/kk01.pdf.

43. Mitsuhashi Niki and Toda Yumiko, "Kanwa kea byōtō kangoshi ga toraeru shūmatsuki gan kanja no higengoteki na supirichuaru pein no sigunaru," *Kōchi Daigaku Kango Gakkai shi* 5, no. 1 (2011): 3–10.

44. WHO Expert Committee on Cancer Pain Relief and Active Supportive Care, *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee* (Geneva: WHO, 1990), 50–51.

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

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

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

48. Ibid., 263.

49. 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.

50. 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.

51. This overlap in labor was noted 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).

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

53. Viktor Frankl, *Man's Search for Meaning* (London: Rider, 2008), 106–8.

54. 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.

55. Ibid., 166.

56. 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.

57. Cadge, *Paging* God, 129.

58. 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. This concern reflects the high amount of religious care that is provided to patients in North America. Koenig, King, and Carson argue that to avoid confusion with psychological care, definitions of patient spirituality should be limited to only those who are pursuing a "religious way of life" or the "transcendent." If this definition was applied in Japan, however, there would be very few instances of "spiritual care" left to consider. Harold G. Koenig, Dana E. King, and Verna Benner Carson, *Handbook of Religion and Health* (New York: Oxford University Press, 2012), 46–47.

59. Tony Walter, "Spirituality in Palliative Care: Opportunity or Burden?" *Palliative Medicine* 16, no. 2 (2002): 133–39.

60. Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (New York: Vintage Books, 1994), 3, 88.

61. Kashiwagi Tetsuo, *Shi ni yuku kanja no kokoro ni kiku* (Tokyo: Nakayama Shoten, 1996), 114–15.

62. For instance, the well-known Davidic psalm, “The Lord is my shepherd” (Psalm 23), includes the line “He [the Lord] restores my *tamashii.*”

63. Kashiwagi, *Shi ni yuku kanja*, 115–17.

64. Kashiwagi, “Yamu hito,” 42.

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

66. Kashiwagi, “Yamu hito,” 40.

67. YCH Website. Accessed January 21, 2016. www.ych.or.jp/en/aboutus.html.

68. Some exceptions include: Fujii Rie and Fujii Miwa, *Tamashii no kea* (Tokyo: Inochi No Kotobasha, 2000), and Tanida, “Supirichuaru kea,” 2–11.

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

70. Kashiwagi, “Yamu hito no tamashii,” 39. 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.

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

72. Ibid., 33–37.

73. 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 no doubt aware 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.

74. Murata Hisayuki, “Shūmatsu gankanja no supirichuraru pein to sono kea,” *Nihon Pein Kurinikku Gakkai shi* 18, no. 1 (2011): 1–8; “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; “Supirichuaru pein no kōzō to kea no shishin,” *Tāminaru kea* 12, no. 6 (2002): 521.

75. 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.

76. Ozawa later began refraining from using this diagram in presentations after readers began to mistakenly attribute it as reflective of Murata’s original theory. Ozawa now prefers to emphasize the importance of interpersonal spiritual care that is more dialogical and not just supportive. Personal communication, September 29, 2021.

77. Kubotera Toshiyuki, *Supirichuaru kea nyūmon* (Tokyo: Miwa Shoten, 2000), 13.

78. Ibid., 43.

79. Kubotera, “Supirichuaru pein no honshitsu,” 392.

80. 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.

81. “Supirichuariti to kokoro no enjo,” in *Iyashi o motomeru tamashii no kawaki: Supirichuariti to wa nanika*,” ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku Shuppankai, 2011), 23.

82. Kubotera Toshiyuki, “Jiko to supirichuariti,” in *Zoku supirichuaru kea o kataru*, ed. Kubotera Toshiyuki and Hirabayashi Takahiro (Hyogo: Kwansei Gakuin Daigaku Shuppan, 2009), 13.

83. Ibid., 14–17.

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

85. 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 kakwaki*, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku Shuppan, 2011), 124, 126.

86. 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.

87. 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 bukkyōsha no shiten o kuwaeru,” in *Zoku, supirichuarukea o kataru*, ed. Kubotera Toshiyuki and Hirabayashi Takahiro (Hyogo: Kwansei Gakuin Daigaku Shuppan Kai, 2009), 77–98.

88. Taniyama Yōzō, “Ancestor and Nature as Foci of Spiritual Care” (paper presented at the ICPCC 2007 World Congress in Poland, August 6, 2007). See also Hara Takahashi, “Buddhist Spiritual Caregivers in Japan,” in *Handbook of Religion, Medicine and Health*, ed. Dorothea Lüddeckens and Jens Schlieter (London: Routledge, 2022), 171–85.

89. “Supirichuaru kea o kō kangaeru: Supirichuaru kea to shūkyōteki kea,” *Kanwa kea* 19, no. 1 (2009): 28.

90. Personal communication, May 9, 2013; see also “Supirichuaru kea wa shūkyōteki kea to kotonatte iru,” *Lifence*, accessed September 26, 2021, https://lifence.gto.ac.jp/2009/08/27/post_66.

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

92. Ōshita Daien, *Iyashi iyasareru supirichuaru kea: Iryō, fukushi, kyōiku ni ikasu bukkyō no kokoro* (Tokyo: Igakushoin, 2005), iii. See also Uchimoto Kōyū, “Supirichuaru kea no shosō (2): Ōshita riron o megutte,” *Momoyama Gakuin Daigaku shakaigaku ronshū* 45, no. 1 (2011): 83–112.

93. Uchimoto, “Supirichuaru kea no shosō (2),” 100.

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

95. Ibid., 15.

96. Kawa Masako also views 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 supirichuaru pein,” *Shiseigaku nenpō* (2005): 48–82.

97. Hongō Kumiko, “Kango no naka no supirichuaru kea o dono yō ni kyōiku suru ka: Kyōiku genba de no genjō 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.

98. *Birth of the Clinic*, 112.

99. Ibid., 9.

100. Ibid., 89. For a classification 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 gengoronteki tenkai” (PhD diss., Momoyama Gakuin Daigaku, 2014).

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

102. Ibid., 11.

103. Tsuchiya Hiroshi, “Sagyō kasetsu to shite no ‘supirichuariti’ no kanōsei to genkai,” *Shūkyō kenkyū* 84, no. 2 (2010): 201–24.

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

105. Sakai Yūen, “Tamashii no iyashi to inochi no kongensei: Supirichuaru kea no ayumi o tōshite,” *Nanzan Shūkyō Bunka Kenkyūjo kenkyūjōhō 19* (2009): 52–66.

106. Ando Yasunori, “Seishin bunseki to supirichuariti,” in *Supirichuariti no shūkyōshi*, ed. Tsuruoka Yoshio and Fukasawa Hidetaka (Tokyo: Riton, 2010), 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 (Tokyo: Keiō Gijyuku Daigaku Shuppan, 2012), 59–81.

107. Fukaya Mie and Shibata Minoru, “Supirichuaru kea to enjosha no shūkyōsei ni tsuite no jisshōteki kenkyū,” *Meiji Gakuin Daigaku Shakaigakubu Fuzoku Kenkyūjo nenpō* 45 (2012): 43–57.

108. See, for example, Marvin D. Delguado-Guay et al., “Spirituality, Religiosity, and Spiritual Pain in Advanced Cancer Patients,” *Journal of Pain and Symptom Management* 41, no. 6 (June 2011): 986–94.

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

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

111. For example, Morita et al., “Existential Concerns.”

112. Horie, “Spirituality and the Spiritual.”

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

114. The imperative to treat the whole person is also found in the writings of the influential Swiss physician Paul Tournier, author of *Médicine de la Personne* (1940). Tournier relates a story of someone who asked him whether his idea of *médicine de la personne* would be better expressed as *médicine pneumo-psychosomatique*, an expression that would add “spiritual” to the idea of patients as “psychosomatic” beings. Tournier voiced his opposition to this idea, claiming that “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.

6. MAKING HEALTHY RELIGION

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

2. Stephen G. Covell, *Japanese Temple Buddhism: Worldliness in a Religion of Renunciation* (Honolulu: University of Hawai'i Press, 2005), 14–18; Rowe, *Bonds of the Dead*, 17–43; John K. Nelson, *Experimental Buddhism: Innovation and Activism in Contemporary Japan* (Honolulu: University of Hawai'i Press, 2013), 45–48.

3. I do not focus on the role Japanese religion plays in psychoanalytic fields like Morita therapy, which has its own rich history. 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). On the role of Buddhism in psychotherapy, see Ira Helderman, *Prescribing the Dharma: Psychotherapists, Buddhist Traditions, and Defining Religion* (Chapel Hill: University of North Carolina Press, 2019).

4. Endō Kōichi, "Christian Social Welfare and the Modernization of Japan," in *Handbook of Christianity in Japan*, ed. Mark R. Mullins (Leiden: Brill, 2003), 343–57.

5. For example, John Nelson cautions that mainstream Japanese temple Buddhism that fails to "engage" society in new ways is "at risk of becoming roadkill on the freeway leading to a more globalized world." This gives the impression that up until recently Buddhists were not "engaged" or "experimental" enough. Nelson, *Experimental Buddhism*, 19. For more on socially engaged Buddhism, see Jessica L. Main and Rongdao Lai, "Introduction: Reformulating 'Socially Engaged Buddhism' as an Analytical Category," *Eastern Buddhist* 44, no. 2 (2013): 1–34.

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

7. Tsuji Zennosuke, *Nihon bukkyōshi 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.

8. Scholars such as Tsuji Zennosuke, Asano Kenshin, Moriya Shigeru, Ikeda Masatoshi, Yoshida Kyūichi, Hasegawa Masatoshi, Tamiya Masashi, and Miyagi Yōichirō have carefully documented charitable works by premodern Buddhists, often glossing them as early examples of social work. For example, Prince Shōtoku (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 Shitenoji, Japan's oldest temple, which included a dispensary (*seyakuin*), hospital (*ryōbyōin*), and home for the needy (*hidenin*) on its premises. 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*, ed. Tamiya Masashi, Hasegawa Masatoshi, and Miyagi Yōichirō (Tokyo: Keisuisha, 1994), 153–72. Scholars also invoke figures like the peripatetic priest Gyōki (668–749), who helped construct shelters (*fuseya*) for the elderly, travelers, the poor and the sick, or Empress Kōmyō (701–760), who helped construct a dispensary at the temple Kōfukuji in 730. Moriya Shigeru, *Bukkyō shakai jigyō no kenkyū* (Kyoto: Hōzōkan, 1971), 189–98. 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 sufferers of Hansen's disease. Moriya, *Bukkyō shakai jigyō*, 239–61, 290–99.

9. Asano Kenshin, *Nihon bukkyō shakai jigyōshi* (Tokyo: Bonjinsha, 1934), 3.

10. For more on Asano's views on Buddhist social work, see Murota Yasuo, *Jinbutsu de yomu shakai fukushi no shisō to riron* (Kyoto: Minerva Shobō, 2010), 142–48.

11. *Kyūsai* 1, no. 1 (1911): [ii], 1.

12. "Charting Known Territory: Female Buddhist Priests," *Japanese Journal of Religious Studies* 44, no. 1 (2017): 77–78.

13. Stone, *Right Thoughts at the Last Moment*, 267–310.

14. Kamii Monshō et al. eds., *Rinjū gyōgi: Nihonteki tāminaru kea no genten* (Tokyo: Keisuisha Hatsubai Hokushindō, 1993).

15. 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, www.genshu.gr.jp/DPJ/kyouka/02/02_044.htm.

16. Saito Masae, *Mikkyō ni okeru rinjū gyōgi 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).

17. In 2015, less than two million of Japan's 127 million residents identified as Christian. Official Statistics of Japan, "Zenkoku shajikyōkaitō shūkyōdantai, kyōshi, shinjasū," accessed December 7, 2017, www.e-stat.go.jp/SG1/estat/Xlsdl.do?sinfid=000031522331.

18. 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 sufferers of leprosy. 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), 155–73. For a historical overview and timeline of Christian social and medical work in Japan, consult Abe Shirō and Okamoto Eiichi, eds., *Nihon kirisutokyō shakai fukushi no rekishi* (Tokyo: Minerva, 2014); and Yajima Yutaka, *Meijiki Nihon kirisutokyō shakai jigyō shisetsushi kenkyū* (Tokyo: Yūzankaku Shuppan, 1982). Also see 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., University of California, Berkeley, 2011); and Hamish Ion, *The Cross and the Rising Sun, Volume 2* (Waterloo, Ontario: Wilfrid Laurier University Press, 1993), 177–79.

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

20. Ono Naoka, "Rainichi iryō senkyōshi to Meiji zenki no Nihon no iryō: 1883 nen Osaka senkyōshi kaigi gijiroku kara," *Bukkyō Daigaku Sōgō Kenkyūjo kiyō* 12 (2005): 36.

21. 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, 1883), 317.

22. 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.

23. 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.

24. Taylor, "Medical Work," 543.

25. Palm, "The Position," 320.

26. Taylor, "Medical Work," 545.

27. Taylor estimates that the total amount spent on medical charity in the Japanese empire (pop. 44 million) was between US$72,500 and $75,000. This compares to US$50 million for the United Kingdom (pop. 39 million) and US$80 million spent for the United States (pop. 80 million). Taylor, "Medical Work," 545.

28. 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 [Tokyo] (Jikei Byōin), another free hospital for the poor and indigent. Taylor, "Medical Work," 546.

29. 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, MI: William B. Eerdmans, 1971).

30. 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.

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

32. 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.

33. Yoshida Kyūichi, *Nihon kindai bukkyō shakaishi kenkyū: Kaitei zōho ban (ge)* (Tokyo: Kawashima Shoten, 1991), 138.

34. *Kyūsai* 4, no. 3 (1914): 50.

35. Yoshida, *Nihon kindai bukkyō (ge)*, 139.

36. Ibid. 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.

37. Yoshida, *Nihon kindai bukkyō (ge)*, 137–38.

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

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

40. Yoshida Kyūichi, *Nihon kindai bukkyō shakaishi kenkyū* (Tokyo: Yoshikawa Kōbunkan, 1964), appendix. 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 in Taiwan and China.

41. 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 jigyō jissensha o chūshin ni,” *NBSFG* 22 (Oct. 1991): 161–74.

42. According to Morinaga, in 1917 Buddhist social work institutions outnumbered Christian ones 140 to ninety. 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 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 jigyō no kenkyū* (Tokyo: Fuji Shuppan, 2013), 7–12.

43. Nakanishi et al., *Senzenki bukkyō*, 70–71.

44. Ibid., 64.

45. Taylor, “Medical Work,” 547.

46. Martin Collcutt, “Buddhism: The Threat of Eradication,” in *Japan in Transition: From Tokugawa to Meiji*, ed. Marius B. Jansen and Gilbert Rozman (Princeton, NJ: Princeton University Press, 1986), 143–67; James Edward Ketelaar, *Of Heretics and Martyrs in Meiji Japan: Buddhism and Its Persecution* (Princeton, NJ: Princeton University Press, 1990), 43–83.

47. 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.

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

49. 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).

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

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

52. Crane, *A Legacy Remembered*, 401.

53. Kirisutokyō nenkan henshū iinkai, ed., *Kirisutokyō nenkan 2017* (Tokyo: Kirisutokyō Shinbunsha, 2017), 714–19.

54. Yodogawa Christian Hospital, "Zenjin iryō ni tsuite," accessed December 7, 2017, http://ych.or.jp/about/zenziniryou.html.

55. 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 bukkyō shakai fukushi jigyō no rekishi*, ed. Hasegawa Masatoshi (Kyoto: Hōzōkan, 2007), 165–68.

56. 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 bukkyōkei shakai fukushi shisetsu, dantai ichiran; Bukkyōkei shakai fukushi jigyō, katsudō tōkei ichiran* (Chiba, Japan: Shukutoku Daigaku Hasegawa Kenkyūshitsu, 2003).

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

58. For example, the Asoka Hospital (est. 2008) and Sensōji Hospital (est. 1952) in Tokyo.

59. Yagi Seiya, "Tōji Saisei Byōin no hensen," *Itan*, no. 96 (2012): 89.

60. 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, www.hpcj.org/list/relist.php. I am also deeply indebted to Taniyama Yōzō for sharing his personal list of religious hospices with me.

61. Saburo Morishita, "Good Works and the Question of Self-Presentation in Tenrikyo," *Nova Religio* 9, no. 2 (November 1, 2005): 33–49, https://doi.org/10.1525/nr.2005.9.2.033.

62. Aura Di Febo, "To Benefit Others Is to Benefit Yourself: Patterns of Social Exchange and Care Provision in a Japanese Lay Buddhist Organization," *Asian Ethnology* 79, no. 2 (2020): 217–38.

63. Aura Di Febo, "The Social Welfare Activities of Japanese New Religions: Risshō Kōseikai as a Case Study," (PhD diss., University of Manchester, 2019), 52.

64. Kashiwagi, *Teihon hosupisu*, 14–15.

65. Ibid., 38–39.

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

67. Fujihara Akiko, "Gendai Nihon hosupisu kō," in *Shukyōgaku to igaku*, ed. Kuroiwa Takuo (Tokyo: Kōbundō, 1991), 120–45.

68. Seirei Mikatahara Hospital, accessed January 21, 2016, www.seirei.or.jp/mikatahara/outline/480.html.

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

70. Nagura Michitaka, "Rōjin no shūmatsu e no fuan to bukkyō shakai fukushi: Anrakushi rongi e no gimon," *NBSFG nenpō* 15 (1984): 79.

71. Tamiya Masashi, Koyama Tsuyoshi, and Kaneto Yoshiiichi, "Bukkyō to rōjin fukushi: Rōjin hōmu ni okeru tāminaru kea," *NBSFG nenpō* 17 (1986): 53–82.

72. Saikō Gishō, “Rōjin, byōnin ni taisuru bukkyō kea,” *NBSFG nenpō* 19 (1988): 109–18.

73. *NBSFG nenpō* 20 (Oct. 1989): 83; *NBSFG nenpō* 21 (Nov. 1990): 22.

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

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

76. Tamiya, *Bihāra no teishō*, 7.

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

78. 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.

79. Tamiya, *Bihāra no teishō*, 36.

80. Ibid., 80.

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

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

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

84. 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.

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

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

87. JSHS, “Bihāra 10kanen sōkatsusho,” March 31, 1999, http://social.hongwanji.or.jp/html/c11p8_04.html.

88. JSHS, “Bihāra no ayunda 20nen,” 41.

89. Ibid., 18–31.

90. The “21” in their name refers to the twenty-first century, further attesting to their reformist vision. There is also a Vihāra Konomien nursing home in Osaka.

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

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

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

94. Barbara Ambros, “My Take: Japanese New Religions’ Role in Disaster Response,” *CNN Belief Blog*, March 22, 2011, 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):

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): 105–37.

95. Timothy Benedict, "Heart Care in Japan: Before and After the 1995 Hanshin Earthquake," *Inochi no mirai* 1 (2016): 147–69.

96. *Asahi Shimbun*, "Makki kanja."

97. *Asahi Shimbun*, "Bukkyō hosupisu."

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

99. *The Marx-Engels Reader, 2nd Edition*, ed. Robert C. Tucker (New York: W. W. Norton, 1978), 54.

100. The word "clinical" (*rinshō*) literally means "bedside."

101. Institute for Engaged Buddhism, "Kenkyūjo shōkai," accessed July 3, 2020, www.zenseikyo.or.jp/rinbutsuken/about.html.

102. NHK, "'Odayaka na shi' o mukaetai: Iryō to shūkyō aratana kokoromi," *Kurōzuappu gendai*, no. 3853 (August 25, 2016).

103. McLaughlin, "Hard Lessons Learned," 105–38.

104. Yoshida, *Nihon kindai bukkyō shakaishi kenkyū (ge)*, 138.

105. Personal interview, January 22, 2015.

106. Accessed December 2017, www.nvn.cc. In October 2015, the counter recorded just over 6,500 visits. In September 2021, the number had reached 10,430. This suggests that the website averages about one thousand visits (not unique visitors) a year. This includes over a dozen of my own visits to the website.

107. McLaughlin, "Hard Lessons Learned," 128.

7. LAST THOUGHTS

1. Suhita Chopra Chatterjee, "Understanding the Experiential World of the Dying: Limits to Sociological Research," *Omega* 41, no. 2 (2004): 91–98.

2. See https://collections.mfa.org/objects/32558 for a digitized image of the painting.

3. Albert Boime, *Revelation of Modernism: Responses to Cultural Crises in Fin-de-Siècle Painting* (Columbia: University of Missouri Press, 2008), 141.

4. Paul Gauguin, *The Letters of Paul Gauguin to Georges Daniel de Monfreid*, trans. Ruth Pielkovo (Toronto: General Publishing, 1992), 62.

5. Michael D. Jackson, "Unhinged Walls, Cracked Signs, and the Rage for Order: Reflections on Art and Anthropology," Clifford Geertz Commemorative Lecture, Princeton University, February 22, 2012.

6. For more on how religion can "organize" life in the American context, see Kathyrn Lofton, *Consuming Religion*, (Chicago: University of Chicago Press, 2017), 4.

7. LeFebvre, "Christian Wedding Ceremonies," 201. LeFebvre draws on the methodology of Ian Reader and George Tanabe's distinction between *cognitive* and *affective* expressions of religious practice. For more on this distinction, see Reader and Tanabe, *Practically Religious*, 129.

8. Kawai Hayao, *Chūkū kōzō Nihon no shinsō*, 6th ed. (Tokyo: Chuō Kōron Shinsha, 2015).

9. For an introduction to emotions in Japanese religions, see Gary L. Ebersole, "Japanese Religions," in *The Oxford Handbook of Religion and Emotion*, ed. John Corrigan (Oxford University Press, 2008). For more on how contemporary Buddhist temples promote themselves by strengthening the affective ties between laity and deities, see Jolyon Baraka Thomas, "The Buddhist Virtues of Raging Lust and Crass Materialism in Contemporary Japan," *Material Religion* 11, no. 4: 485–506. doi:10.1080/17432200.2015.1103476. See also Erica Baffelli et al., "The Aesthetics and Emotions of Religious Belonging: Examples from the Buddhist World," *Numen* 68, nos. 5–6 (2021).

10. Takashi Nishide, "Taiwan Leads Asia in Spiritual Care to Alleviate Fear of Death," *Japan Times Online*, May 21, 2014, www.japantimes.co.jp/news/2014/05/21/national/taiwan-leads-asia-spiritual-care-alleviate-fear-death.

11. 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* (London: Routledge, 2013); Ugo Dessì, *The Global Repositioning of Japanese Religions: An Integrated Approach* (London: Routledge, 2016).

12. Roland Robertson, "Glocalization: Time-Space and Homogeneity-Heterogeneity," in *Global Modernities*, ed. Mike Featherstone, Scott Lash, and Roland Robertson (London: Sage Publications, 1995), 28–32.

13. Nicholas Standaert observed in his analysis of the cultural transmission of Christianity to China that 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. Nicolas Standaert, "Christianity in Late Ming and Early Qing China as a Case of Cultural Transmission," in *China and Christianity: Burdened Past, Hopeful Future*, ed. Stephen Uhalley Jr. and Xiaoxin Wu (Armonk, NY: M. E. Sharpe, 2001), 88–89.

14. Paul Willis, *The Ethnographic Imagination* (Cambridge: Blackwell, 2000), 118.

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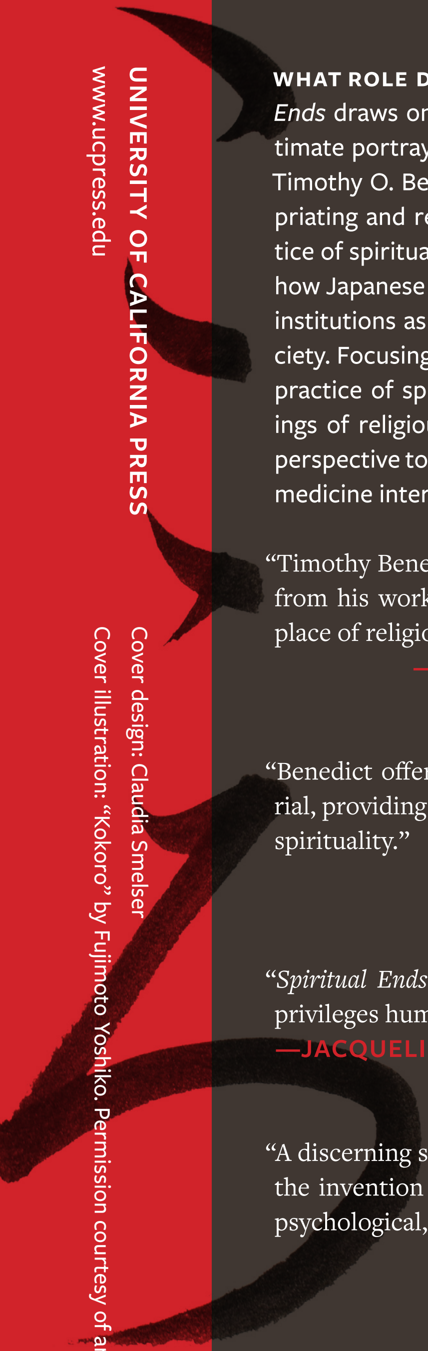

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