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

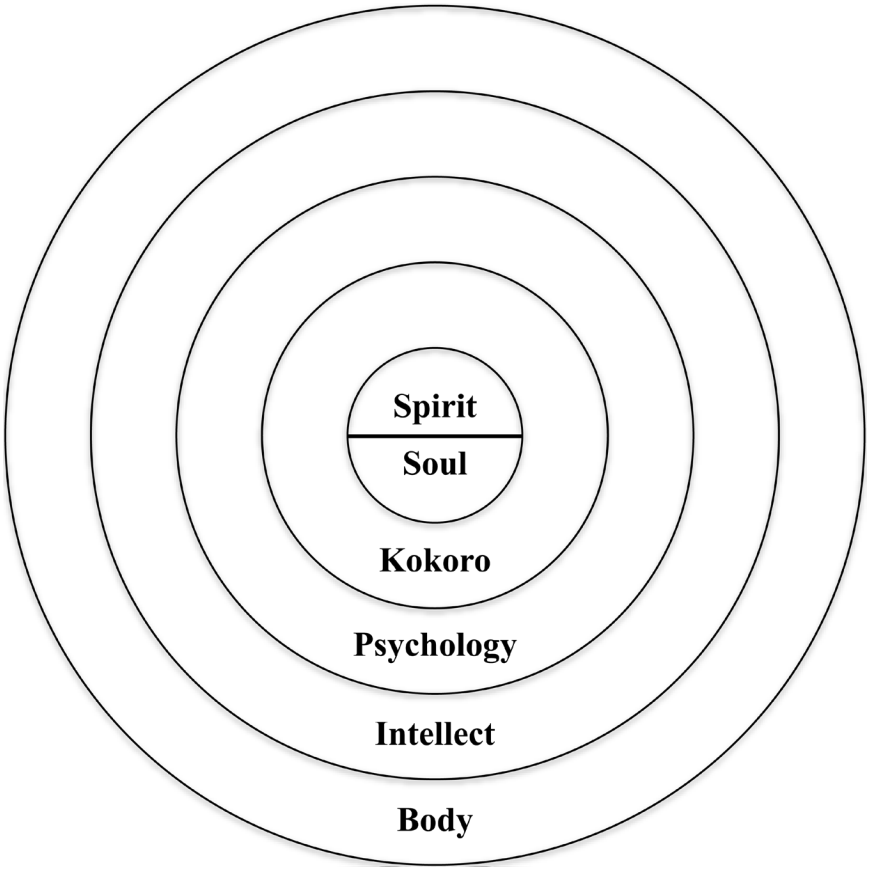

FIGURE 3. Human dimensions (Waldemar Kippes, *Supirichuaru kea: Yamu hito to sono kazoku, yūjin oyobi iryō sutaffu no tame no kokoro no kea* [1999; reprint, Tokyo: San Paolo, 2010], 58).

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*

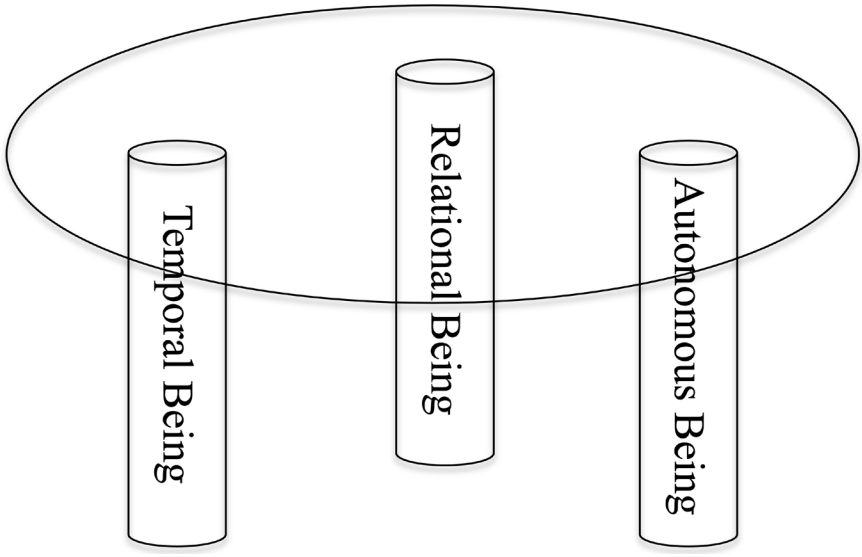

FIGURE 4. Three supports for existence (Ozawa Taketoshi, *Iryōsha no tame no jissen supirichuaru kea* [Tokyo: Nihon Iji Shinpōsha, 2008], 67).

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

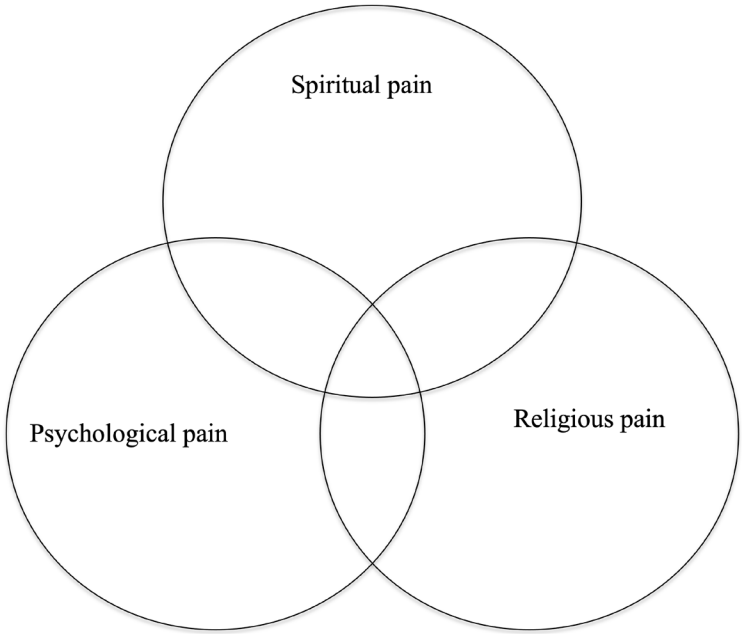

FIGURE 5. *Kokoro* pain (Kubotera Toshiyuki, *Supirichuaru kea gaku josetsu* [Tokyo: Miwa Shoten, 2004], 46).

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

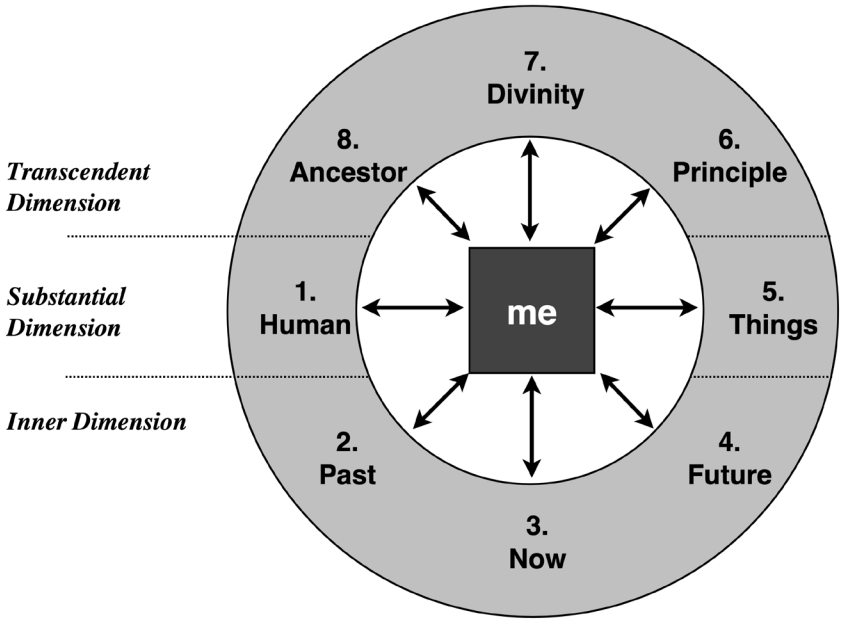

FIGURE 6. The structure of spiritual care (Taniyama Yōzō, "Nihonteki, bukkyōteki yōso o kuwaeta supirichuaru kea ron," *Bukkyō fukushi* 10 [2007]: 77).

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

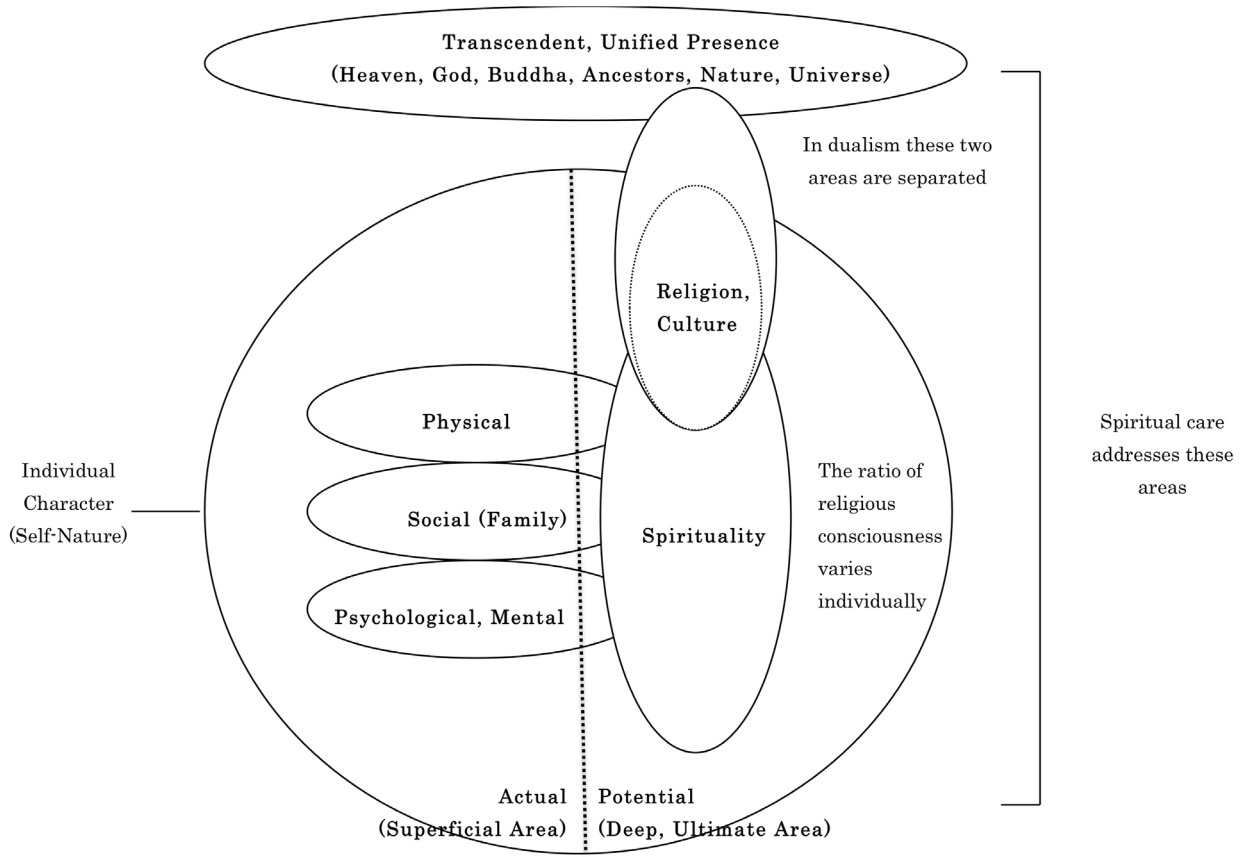

FIGURE 7. Conceptual diagram of spirituality and spiritual care (*Ōshita Daien, Iyashi iyasareru supirichuaru kea: Iryō, fukushi, kyōiku ni ikasu bukkyō no kokoro* [Tokyo: Igakushoin 2005], 2323).

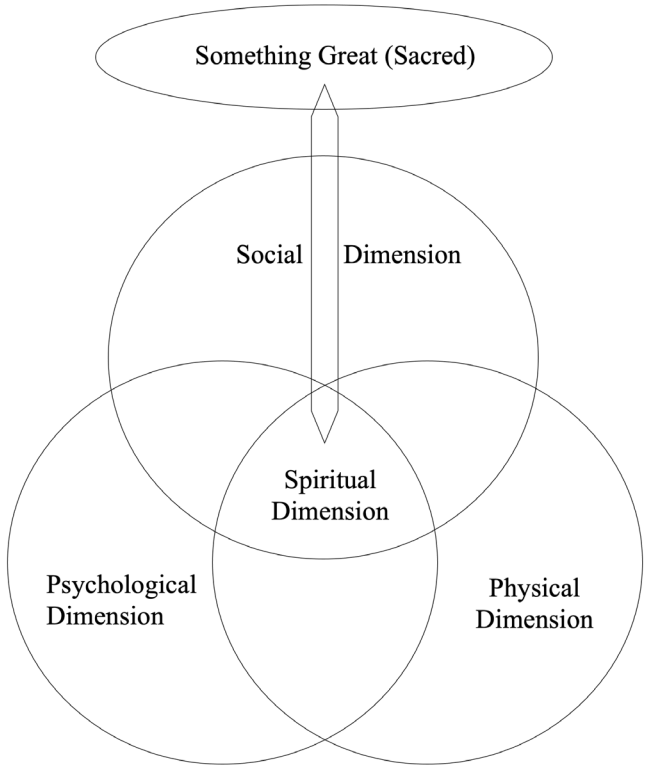

FIGURE 8. The relationship between spirituality and something great (Takagi Yoshiko, "Genba kara mita pasutoraru kea to supirichuaru kea, guriifu kea," in *Kōza supirichuarugaku dai 1kan*, ed. Kamata Toji et al. [Kanagawa: Beingu Netto, 2014], 66).

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

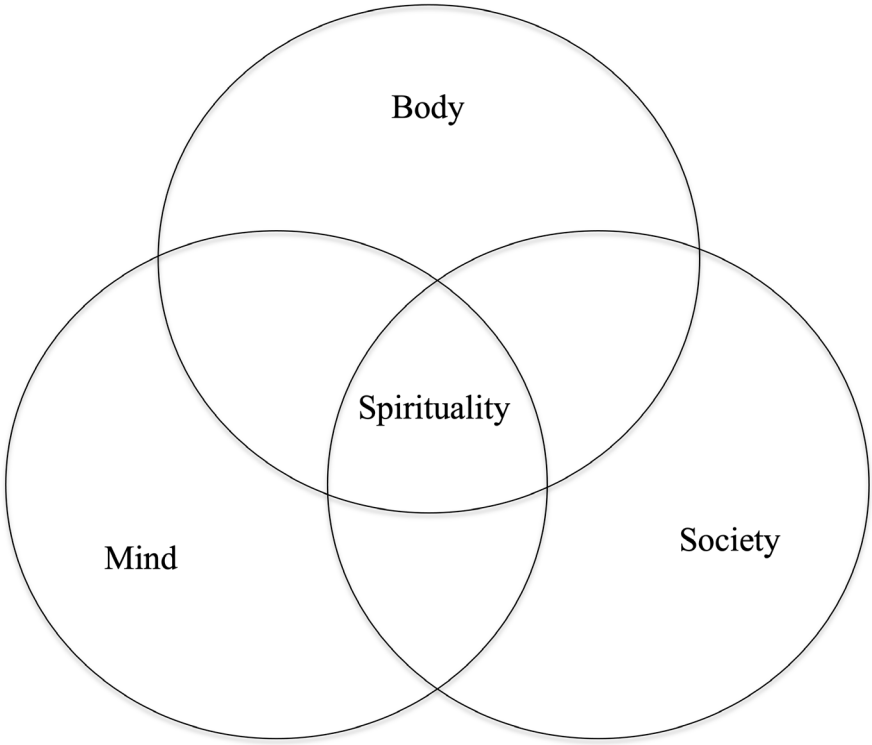

FIGURE 9. The location of spirituality (Yamazaki Fumio, "Ningen sonzai no kōzō kara mita supirichuaru pein," *Kanwa kea* 15, no. 5 [Sept. 2005]: 378).

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]