

Timothy O. BENEDICT

Practicing Spiritual Care in the Japanese Hospice

This article introduces how spiritual care is practiced in Japanese hospices to fit the needs of nonreligious patients. It suggests that Japanese chaplains often go beyond helping patients vocalize spiritual pain and addressing anxieties through counseling, religious support, or being a sympathetic presence. Rather, much of spiritual care is also conducted in the margins of daily care, and through special group events or even prosaic activities—an approach that elicits less resistance by Japanese patients. This article will also discuss how examining the practice of spiritual care helps to problematize terms like “secular” or “post-secular” in Japanese society and point out the ways in which spiritual care is being marshaled by contemporary religious groups, chaplains, the media, and religious studies scholars to help valorize the role religion can play in Japanese society by emphasizing its psychotherapeutic contributions.

KEYWORDS: spiritual care—chaplaincy—hospice—Vihāra—secularism

Timothy O. BENEDICT is a PhD candidate in religion at Princeton University.

ON 25 August 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 sat 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."

Care for the dying has grown to become a topic of national concern in Japan. In 2016, 27.3 percent of Japanese were aged sixty-five or older—the highest percentage in the world. By 2065, this number is expected to rise to a staggering 38 percent, meaning that more than one out of three Japanese will be aged sixty-five or older (NATIONAL INSTITUTE 2017). As Japan's population grows grayer and grayer, naturally this will continue to put extreme pressure on families in caring for their elders at the end of life. In response, the number of hospices in Japan has grown over the last three decades from just a handful to nearly four hundred (HPCJ 2017). The growth of the hospice movement has also brought attention to the practice of spiritual care for dying patients—typically provided by religious professionals called chaplains. In Japan however, where the term "spiritual care" is rendered in *katakana* syllabary (スピリチュアルケア) to denote its foreign origin, hospice workers are still grappling with how they should define spiritual care and practice it.¹

In light of the ambiguity of what spiritual care actually refers to, this article will draw on ethnographic fieldwork conducted at several Japanese hospices to consider what spiritual care looks like in practice. Spiritual care in Western settings

* I would like to thank my colleagues at the Center for the Study of Religion and members in the Work-shopping Asian Religion Papers (WARP) group at Princeton University for their feedback on earlier drafts of this article. I would also like to thank Shigehisa Kuriyama and Levi McLaughlin for responding to conference versions of this paper. And finally, I would like to extend a special thanks to the anonymous JJRS reviewers for providing some very insightful suggestions and comments.

1. This confusion is seen for example in the conference themes for the 2015 and 2016 Japan Society of Spiritual Care Annual Conference, which were "Understanding and Defining Spiritual Care" (*Supirichuaru kea no rikai to sono teigi* スピリチュアルケアの理解とその定義), and "Illuminating the Foundations of Spiritual Care: Thinking Together on its Definition" (*Supirichuaru kea no konpon o terasu: Tomo ni teigi ni tsuite kangaeru* スピリチュアルケアの根本を照らす—共に定義について考える).

generally refers to providing patients with religious or existential support as patients deal with deep questions about the meaning and purpose of life, guilt and regrets, isolation, or concerns about the afterlife (PULCHASKI 2012). Rather than staking out a predetermined definition of spiritual care and searching for examples of it, this article will examine the range of meanings and practices Japanese hospice workers attach to the concept of spiritual care in their daily clinical work. I will focus on one of Japan's three mainline Buddhist hospices—also known as a *Vihāra ward*—where I conducted two weeks of participant observation in the fall of 2014.² This hospice had over twenty beds and at the time employed three full-time Buddhist chaplains (and one trainee) who were called *Vihāra priests*. I will also reimagine what constitutes the core of spiritual care in Japan by demonstrating several different ways in which spiritual care is offered to Japanese patients. These include what I term supportive care, vocal care, and resonating care. This article will focus on “supportive care,” which refers to a type of spiritual care that goes beyond helping patients vocalize spiritual pain and directly addressing their anxieties through counseling, religious care, or being a sympathetic presence. Instead, much of spiritual care is also conducted “supportively” in the margins of daily care such as through special hospice events or even in the course of prosaic activities. This approach elicits less resistance by Japanese patients than do models of spiritual care that borrow from a Western emphasis on religious or existential care found in the tradition of pastoral counseling.³ In Japan, chaplains at the bedside are quick to recognize that the cultural foundation for offering prayer, reciting sutras, conducting religious rites, or the candid discussion of religion and existential issues with dying patients who have never even heard of the word “spiritual care,” or who generally view religious professionals with suspicion, is weak. In this way, the Japanese case also serves as an instructive example for global understandings of how hospice chaplains go about providing spiritual care to nonreligious patients.

This article will also put the vocation of chaplaincy in Japan in conversation with the topic of secularization in Japanese society. I will suggest that the example of spiritual care helps to problematize one dimensional understandings of

2. This research was conducted with hospice approval and was also vetted by the Princeton University Institutional Review Board. Between 2014–2015, I also conducted two weeks of participant observation at a Catholic hospice, two weeks at a Protestant hospice, and a series of shorter visits to nine other hospices in Japan and three in Taiwan. In addition to daily interactions with hospice staff and patients during my fieldwork, separate interviews were conducted with thirteen chaplains, eleven doctors, twenty-five nurses, and nine hospice patients.

3. This is not to say that supportive care is less important in Western contexts. As one American chaplain explained to me, “That sounds a lot like what we do!” However, the degree to which supportive care is utilized in Japan, as well as in the reasons for its use, are different compared to North American or European contexts where spiritual care is a familiar term and patients have clearer expectations about the kinds of services chaplains are able to provide.

what might be called “secular” or “post-secular” in Japanese society, and also point out the ways in which the spiritual care movement is being marshaled by contemporary religious groups, chaplains, the media, and religious studies scholars to help valorize the role religion can play in Japanese society by emphasizing its psychotherapeutic contributions. In the end, I suggest that a closer, especially ethnographic, study of how religious groups are engaging in various psychotherapeutic activities provides an opportunity to examine how religion in contemporary Japan is both shaping and being shaped by medical spaces and practices.

The State of Hospice Chaplaincy

Hospice care was first introduced in Japan at several Christian hospitals in the early 1980s, and shortly thereafter, Christian doctors and clergy began to articulate a vision of how to provide spiritual care to patients. Since hospice care began in Christian hospitals, the first dedicated providers of spiritual care referred to themselves as “chaplains” (*chapuren* チャプレン) and this title has remained common.⁴ In the late 1980s, the Buddhist hospice or *Vihāra* ビハーラ movement also began to establish several training programs for priests and parishioners to provide spiritual care to patients. A key figure in the Buddhist hospice movement was Tamiya Masashi who first used the Sanskrit term “*Vihāra*” in 1985 to refer to Buddhist hospice care in Japan. Tamiya intended the term “*Vihāra*,” which literally means “abode,” and refers to monasteries, retreats, or places of rest, to serve as a Buddhist alternative for the word “hospice” which he saw as laden with Christian connotations (TAMIYA 1988, 124). Priests who work in *Vihāra* wards sometimes also refer to themselves as “*Vihāra* priests” (*bihāra sō* ビハーラ僧) instead of as “chaplains.”

A major watershed in the practice of spiritual care came in 2007, when the Japan Society of Spiritual Care (JSCC) was formed by an ecumenical consortium of Buddhist, Christian, and nonreligious medical workers, religionists, and academics with the goal of establishing a nationwide spiritual care training and certification program. Between 2012 and 2016 the JSCC extended basic spiritual care certification to 170 individuals (JSCC 2017). However, not all who received this certification work as chaplains, nor do all chaplains feel the need to pursue certification.⁵ Although the efforts of the JSCC to push for hospital chaplaincy

4. Other job titles for spiritual care include “spiritual care worker” (*supirichuaru kea shi* スピリチュアルケア師 or *supirichuaru kea wākā* スピリチュアルケアワーカー), “spiritual care counselor” (*supirichuaru kea kaunserā* スピリチュアルケアカウンセラー), “pastoral care worker” (*pasutoraru kea wākā* パストラルケアワーカー), and most recently, “clinical religious worker” *rinshō shūkyōshi* 臨床宗教師.

5. There are currently no official statistics on the total number of chaplains in Japan. According to a 2012 report published by the Japan Hospice Palliative Care Foundation, there were an estimated 176 chaplains working or volunteering at 68 different palliative care wards around

as a bona fide vocation in Japan has made some small gains, overall, public recognition of chaplains' work in Japan remains weak. For example, between 2009 and 2011, I worked as a hospital chaplain in Japan, but nobody knew what I did. When I introduced myself as a "chaplain" to patients, they would look confused and query: "Charlie Chaplin?" Even after I explained that my job was to just listen and converse with them, they would often ask, "Are you sure you don't have any work to do?" Although media attention to the vocation of chaplaincy has helped to raise its profile in recent years, what exactly hospital chaplains are supposed to do, or what spiritual care really means in the Japanese context still remains an enigma for many.

Previous Scholarship

Studies on spiritual care in Japan generally fall into two categories. First, there are studies that are written by and for hospice workers. These studies are found in palliative care journals like *Kanwa Kea* and frequently adopt a normative tone. They also generally lack a reflexive concern for what spiritual care in hospices can tell us about the broader context of contemporary Japanese religion. Instead, these studies, including three issues of *Kanwa Kea* that focused on the topic of spiritual care in September 2005, January 2009, and May 2012, are rightfully concerned about how the hospice staff might go about providing the best possible spiritual care to patients. Another category of studies is produced by a growing number of Japanese religious studies scholars who have connected the role of religion in medical settings to what they see as a broader public interest in the topic of spirituality (*supirichuariti* スピリチュアリテイ) in modern Japan.⁶ These studies attend to the historical reasons for why spirituality has become a buzzword in the media, the medicalization of spiritual care, the discursive contestation over what constitutes spiritual care, and why religious professionals are seeking to engage in spiritual care in the first place (SHIMAZONO 2007; ANDŌ 2010; KASAI and ITAI 2013). But whereas the former body of scholarship helps delineate varying perspectives on idealized models of spiritual care, and the latter demonstrates the larger religious and social context for this movement, they both lack attention to the actual lived practice of spiritual care in the hospice setting. What does a typical day look like for chaplains? What are some of the

Japan (MURASE et al. 2012). However, FUJIYAMA Midori estimated in the same year that there were only 60 chaplains at 37 hospice institutions (2012). According to the Hospice Palliative Care Japan Website, in 2017, 58 of their 331 member institutions provided some sort of spiritual care to patients or their families through religious workers and volunteers. I estimate there are currently around one hundred active chaplains in hospices throughout Japan.

6. For an overview of the "spiritual boom" in Japan, see SHIMAZONO and GRAF (2012); SAKURAI (2009). For questions on whether this "boom" may be exaggerated, see READER (2012 and 2013).

concrete ways they interact with patients? What practical principles guide their work? These are some questions that have yet to receive concentrated attention.

In addition, many of these studies also take the term “spiritual” for granted, or even unwittingly celebrate it.⁷ In addition to operationalizing a very ambiguous concept, the latent danger of this approach is that it often uncritically demarcates “spiritual” from “religion” by portraying the former as individualized, interiorized, and non-dogmatic, and the latter as its opposite: institutionalized, exteriorized, and dogmatic. This not only reifies these categories, but also obscures the ways individual beliefs and practices are socially constituted. More perturbingly, these portrayals also lapse into confusing scholarly classification with theological judgment (HORIE 2009; WOOD 2010; MARTIN 2014; HERMAN 2014). For instance, the celebration of public interest in “spirituality” as embodying a liberal individualistic alternative to authoritarian religious beliefs and modern rationalism is also found in Western scholarship where the interpretive categories of “self” and “freedom” oftentimes reproduce the very discourses on spirituality they seek to describe (MITCHELL 2011). In short, even ostensibly academic studies of spiritual care can fall into celebrating spiritual care as emblematic of the potential for a postmodern, individualistic, ecumenical, and non-authoritarian form of religious social activism and religious subjectivity. By contrast, this article will take a more cautious approach. My interest in the spiritual is not in describing it as a third space of not religion and not secular, or of celebrating it. As a matter of fact, the empirical evidence as to whether there is a sustained “boom” of Japanese public interest in spirituality remains specious (READER 2012, 30). Rather, without denying that spiritual care can greatly benefit hospice patients, I hope to show how a closer look at the practice of spiritual care also reveals how religion is not only marshaled, but also marginalized in ways that complicate the narrative that hospital chaplaincy represents an example of revitalized religion in the Japanese public sphere.

7. For instance, SHIMAZONO Susumu, who has done much to pioneer the study of spirituality in Japan, 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 (2012, 7, 140). KASHIO Naoki 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 (2012, 3) and has published a book that is optimistically titled, “The Spiritual Revolution: The Potential of Contemporary Spiritual Culture and the Opening of Religion” (2010). Likewise, HAYASHI Yoshihiro expresses his hope that spirituality will serve the members of Japanese society whose hearts have lost their bearings (2011, iii).

Religious Services for Patients

The day begins and ends in the Vihāra ward with a service called *omairi* お参り (lit. “visiting”).⁸ Staff and patients enter the Vihāra Hall where they take prayer beads and a small volume of sutra excerpts in hand. They then follow the Vihāra priest in reciting the “Verses of the Serious Vow” (*jūseige* 重誓偈) in the morning and the “Verses of Praises to the Buddha” (*sanbutsuge* 讃仏偈) in the afternoon while facing the Buddhist altar at the front of the room. Each recitation takes about ten minutes. During the afternoon *omairi*, one of the Vihāra priests also delivers a short sermon of about ten minutes that is humorous or inspirational.

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

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

The *omairi* service was the closest thing to religious care provided by the Vihāra priests. Before the service, the priests would don their Buddhist robes

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

(*kesa* 袈裟) and after the service these would be exchanged for either polo shirts or Buddhist working clothes (*samue* 作務衣) for the rest of the day. The only other time the priests would wear their Buddhist robes was during an optional “farewell service” (*owakare-kai* お別れ会) that took place in the Vihāra Hall after a patient died. During this ceremony the patient’s bed was placed in front of the Buddhist altar and a patient’s favorite item, such as a family photo, placed on the altar. On one occasion the priest placed a can of coffee on the altar in memory of the patient who had liked to frequent the hospice vending machine. After all the available staff gathered in the room, the priest chanted one of the sutra recitations used during *omairi*. Next, staff members shared their memories of the patient with family members until the hearse arrived.

Daily Activities

So what other kinds of care did the Vihāra priests provide? As I shadowed them in their daily work, what struck me most was how they endeavored to “live with” patients. For example, the priests often made a point of wheeling patients out for a nature walk through some nearby fields when the weather was nice. These walks were full of lighthearted conversations with patients about past occupations or about family interspersed with commentary on passing scenery. The priests also managed a small garden behind the hospice where patients could plant vegetables or flowers. In the fall, harvested onions could even be seen drying on a patient’s veranda. The priests also ate lunch with patients in the common area, and seasonal events were integrated into daily care. For example, during the autumn equinox we helped patients make soft rice cakes (*ohagi* お萩).⁹ Patient birthdays were also enthusiastically celebrated. Afterwards, pictures from these events were given to patients to pin on their wall or to family members as keepsakes.

At times, special events might also be tailored with certain patients in mind. For example, one patient enjoyed watching films. After learning of this, the Vihāra priests set up a screen and projector in the Vihāra Hall and brought in couches. The nutritionist made popcorn, someone else made some movie ticket stubs, and they hastily arranged a film viewing for the afternoon. The room was also rearranged so the Buddha image in the front of the room could enjoy the film—a spaghetti Western. The patient was all smiles as she handed in her ticket and entered the makeshift theater.

In between such activities, the Vihāra priests also visited patients. One patient who I call Shitakubo-san was in his seventies and had lung cancer. When we visited him in his room one afternoon he was a little sleepy but alert. The Vihāra priest, Rev. Sasaki, spoke with him about his eldest son who had visited the day

9. *Ohagi*, covered with sweetened red bean paste, are traditionally made for visiting ancestral spirits (and consumed) during the autumn equinox.

before and about his two other children. Shitakubo-san was concerned about who would take care of the family's Buddhist altar. He doubted his eldest son could do it and it was not clear if his second son would be willing to move home. He had considered the possibility of selling the house and dividing the estate between the children but was worried that once the house was gone the siblings would go their separate ways.

After we left his room, the Rev. Sasaki explained to me how important it was to have these kinds of conversations with patients. Although Shitakubo-san showed little concern for his own condition, he did worry over what would become of his family. Rev. Sasaki saw himself as playing a mediating role by conveying information to family members who found it difficult to discuss these issues with Shitakubo-san directly while he was still alive. We visited Shitakubo-san again after he had spent a night at home. After chatting about how things went, Rev. Sasaki commented: "Shitakubo-san, you aren't really the type to outwardly express anxiety (*fuan* 不安), are you?" He replied: "I might just be thick-headed ... I'm an atheist too..."¹⁰ After we left his room, Rev. Sasaki mentioned to me, "I think that he is feeling spiritual pain somewhere. He calls himself an atheist (*mushinronsha* 無神論者) but he uses the Buddhist word for "life and death" (*shōji* 生死) and I saw him reading a book about Shinran 親鸞.¹¹ Japanese simply just don't show their religious views much up front."

The Lack of Religious Care

In general, other than the *omairi* services, sustained conversations with patients on religious topics or the provision of religious care did not occur on a daily basis in the hospice. In fact, even the *omairi* services were framed as a traditional rite that many nonreligious Japanese might conduct at home in front of their Buddhist altar. As Taniyama Yōzō, a former Vihāra priest, has pointed out, 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 that attracted a fair number of patients (SUPIRICHUARU KEA JIREI 2011, 130). At another hospice affiliated with a Buddhist New Religious group, Risshō Kōseikai 立正佼成会, a doctor explained, "We thought we needed chaplains on call twenty-four hours a day, 365 days a year, and so we were able to create such a system with everyone's cooperation. However, after a year or two had passed, we found that there was no demand from anyone to talk with such chaplains" (HAYASHI 2012, 63). Ultimately, this hospice chose to discontinue having a full-time chaplain on call for this reason.

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

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

There are several explanations for why hospice chaplains have few opportunities to provide religious care. First, as stated earlier, many patients have only a vague idea of who the chaplain is or what their work entails. Second, many patients are simply not in the hospice long enough to receive such care. In the year 2000, for example, 92 percent of patients stayed in a hospice for thirty days or more; but by 2015 this number had shrunk to 54 percent (IGARASHI and MIYASHITA 2017, 81).¹² What this means for chaplains is that instead of getting to know a patient over several months, increasingly, they must acquaint themselves with a patient over a space of weeks. Moreover, since these weeks come at the end of life, many patients arrive in serious condition, making the window of opportunity for communication difficult. Many patients can barely eat, are heavily sedated, or have trouble breathing. In short, with an increase in the number of patients with low alertness or communication abilities, there are simply fewer opportunities to have meaningful conversations with patients.¹³

Third, the lack of explicit religious care by chaplains is also due to the fact that many Japanese remain suspicious of religious professionals. In a 2012 general population survey conducted by the Japan Hospice Palliative Care Foundation, more than half of respondents stated that they felt “religion would support their *kokoro* (mind/heart 心) 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% felt a religious professional would help support their *kokoro* (JHPC 2017). In other words, it is not so much that Japanese patients have a poor image of religion so much as they have a poor image of religious professionals.

This suspicion toward religious professionals was particularly exacerbated after the new religious group Aum Shinrikyō オウム真理教 carried out a sarin gas attack in the Tokyo subway system in 1995 (BAFFELLI and READER 2012). In the aftermath of this attack, new legal restrictions were placed on religious groups and public trust in religious organizations eroded to an all time low, at about 13% (KISALA 1999, 65). In a climate where the media regularly portrayed religious groups as dangerous entities, religious workers in medical settings were forced

12. One reason for this is that as anticancer treatments and drugs have improved, patients can choose to pursue aggressive medical treatment at the end of life without suffering painful side effects. 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.

13. 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.

to temper their approach. For example, one Catholic hospice chaplain explained that prior to 1995, she would often introduce herself to patients as a “religious provider” (*shūkyō teikyōsha* 宗教提供者) and patients would respond positively. After the Aum incident, she began describing her work as simply “heart” or “mind care” (*kokoro no kea* 心のケア) to avoid a negative reaction. Vihāra priests similarly played down their religious expertise. Instead, they framed their contribution as helping to make the hospice feel like a natural place to live and die. Since many Japanese homes contain a Buddhist altar, the Vihāra Hall and *omairi* services were explained as part of their efforts to make patients feel at home.

Defining Spiritual Care

Because the practice of spiritual care takes so many forms, an argument can be made that there should not be just one definition of what it is (KONISHI 2013, 65). Andō Yasunori makes this point by suggesting that definitions of spiritual care should not focus on what is being done, but on the relationship between staff and the patient.

In other words, as I said before, spiritual care isn't something that you can say, “This is it!” and put into a manual. Rather, the medical worker and patient encounter each other as fellow human beings, and within each specific interchange, a kind of resonance (*kyōmei* 共鳴) arises between them. When a “space” is formed where spiritual events (things that are too deep in meaning to be easily dismissed as happenstance) can easily occur or not be hindered, the regular care toward the patient “becomes spiritual,” and “takes on the meaning of spiritual care.” In this way, spiritual care is something that is generated in each situation. (ANDŌ 2008, 19)

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

I think you can define spiritual pain, but spiritual care cannot be defined. So, for instance, you could say that any kind of care that makes the patient feel valued (*taisetsu* 大切) is spiritual care. For example, let's say a patient wants to eat a watermelon in the middle of the winter. You search through various stores and bring it to the patient to eat. In a sense, I think this too is spiritual care. (Personal interview, 22 January 2015)

From this perspective, spiritual care is generated from the heart. Chaplains and staff are simply asked to value the patient.

So what does this look like in practice? In the next section, I focus on three ways that spiritual care is commonly practiced in Japanese hospices: supportive care, vocal care, and resonating care. These somewhat artificial labels help to outline the range of ways in which spiritual care is practiced and are not intended to

have analytical import. Primarily, they help focus attention on the *way* spiritual care is practiced rather than on the *content* of the care, which, as Andō points out, could include almost anything. In short, these categories examine what spiritual care looks, sounds, and feels like. Approaching spiritual care from a phenomenological perspective also helps us better understand the embodied nature of spiritual care. In this article, I focus on supportive care, but will first briefly explain what I mean by “vocal care” and “resonating care.”

Vocal and Resonating Care

Vocal care refers to spiritual caregivers listening to and conversing with patients. They give encouraging words, exchange personal stories, and ponder deep questions together. The conversations Rev. Sasaki had with Shitakubo-san are one example of this kind of care. In medical literature vocal care is often 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 share their stories and, as the listener provides an affirming ear, the patients create meaning for themselves and find healing (TANIDA 2011). Vocal care may also include religious care. Chaplains may read, recite, or sing scripture with the patient or answer questions about guilt, forgiveness, anger, or the afterlife from their own religious perspective. For example, one Vihāra priest describes a patient who confessed to him that she had not conducted memorial services for a fetus she had aborted when she was young. Since she strongly felt that her current illness was due to this lapse, the priest hastily arranged for a memorial service that gave her great relief (HANAOKA 2012).

Resonating care on the other hand places emphasis on physically *being* with the patient. In addition to affirming the patient’s daily life through activities or providing a listening ear to concerns, resonating care sees the presence of the spiritual caregiver as itself a form of spiritual care. By being present with the patient, the caregiver embodies empathy and allows the patient’s suffering to resonate (*kyōmei* 共鳴) in their being. Resonating care also claims no techniques other than spending quality time with the patient. As one hospice nurse explained:

I think the most important thing is to continually be with the patient. The fact is that there are questions that have no answers. I’m sure that the patients aren’t necessarily seeking answers—and we don’t know the answer anyway. So in such cases, I try to stay with the patient without running away.

(Personal interview, 11 June 2015)

A nurse who worked on a palliative care team at another hospital echoed a similar understanding when explaining how she responded to patients who asked difficult spiritual 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. (Personal interview, 21 May 2015)

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

Supportive Care

Supportive spiritual care refers to creating a hospice environment that helps patients affirm their value in the midst of the dying process. At the most basic level, supportive care includes designing hospice facilities so that patients feel at home. Spiritual caregivers also pay attention to and support the patient’s favorite activities, arrange for social events, and engage in small talk to help stave off feelings of isolation. It is a form of spiritual care through small touches that in their aggregate help patients feel valued, appreciated, and supported as they face the end of life. In the Vihāra ward for example, 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. The priest explained to me that even when patients were unable to join them, it was important for patients to be able to hear the sounds and see rhythms of home life.

One day, Rev. Sasaki showed me a picture of a large (1200 cc) motorcycle. It had belonged to a middle-aged male patient who was a strong motorcycle aficionado. In fact, he rode the motorcycle to the hospice and parked it on his ground room veranda where he could gaze at it from his bed. His love for the motorcycle was so great that he even used its side mirrors to shave in the morning. Seeing this, several staff members who were also motorcycle enthusiasts arranged to bring their own motorcycles to the hospice and created an impromptu biker rally, much to the patient’s delight. The Rev. Sasaki shared this memorable anecdote with me to demonstrate the ways staff tried to make the hospice a place

where it was hard for spiritual pain to arise (*supirichuaru pein ga denikui basho* スピリチュアルペインが出難い場所). Rev. Sasaki jokingly explained, “You might even say that we are doing preventive spiritual care.”

One of the Vihāra priests also 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 a person to ride on it, they would likely be scared. It is only because you have space on either side that you can ride the bicycle confidently. In the hospice, he explained, medical care corresponds to the part where the tire touches the ground; it is indispensable to running a hospice. But the Vihāra priest’s job is to be the rest of that path. Without the support of spiritual care that the Vihāra priests provide, entering the hospice would be a scary ride.¹⁴

Finally, supportive care also stresses the importance of supporting the patient’s ability to die in a way that reflects who they are (*jibunrashiku shinu* 自分らしく死ぬ). One nurse at a hospice near Osaka explained her approach to spiritual care as follows:

If patients can still communicate, we find out what their daily life was like up until this point. Or if it is difficult to communicate with them, we get information from their family and find out what we as a hospital can do to help the patients be themselves. So if eating was something that held meaning for them, even if it is difficult to eat, we let them taste some food. During conferences, we also discuss what the patients need most, and what it is that we can do right now to support them in being who they are. (Personal interview, 8 June 2015)

As these descriptions of supportive care suggest, despite the often repeated mantra in spiritual care literature that it is more important to be there for patients than to *do* something for patients, the staff and chaplains in fact *do* a great deal in the practice of spiritual care. Creating a makeshift movie theater, harvesting onions, and going on nature walks are all described as part of spiritual care.

Is Spiritual Care Post-Secular?

In the introduction to a recent special issue of the *Journal of Religion in Japan*, Fujiwara Satoko questions whether a new post-secular movement is occurring in Japan. By “post-secular” Fujiwara refers to activities by Japanese religious groups in the public sphere based on a conventional (that is, Western) concept

14. A chaplain at a Protestant hospice in Kyushu also echoes this description of spiritual care. He explained that in his view, the design of hospice facilities, small talk with patients, and various events and activities all function as forms of “spiritual support” (KIYOTA 2015).

of religion with “the secular” as “the other” (FUJIWARA 2016, 99). The authors in this issue raise a number of case studies that refer to the role religious groups are playing in politics, in disaster relief, and education. The broader point that Fujiwara and the individual authors collectively make is that these examples are not necessarily evidence of a revival of religion in the public sphere, but rather show how various agents are utilizing religion for secular purposes (FUJIWARA 2016, 100). For example, the interfaith chaplains who have worked to console and counsel victims of various forms of trauma in the wake of the 11 March 2011 Tōhoku tsunami disaster have attracted a large amount of media and scholarly attention and are touted as evidence of one of the new roles religious groups are taking on in the public sphere (KOKUSAI SHŪKYŌ KENKYŪJO 2012). Takahashi Hara examines this phenomenon and does not deny that the work of interfaith chaplains is ostensibly post-secular in that religious professionals are entering new nonreligious spaces. However, he cautions that although their work occurs in the interstices between religion and the secular, their actual activities tend to be more psychotherapeutic than religious in nature (TAKAHASHI 2016). This reinforces Fujiwara’s point that these so-called post-secular examples of religious activism tend to manifest values that can “easily be approved, shared, or promoted by people who deem themselves non-religious or secular” (FUJIWARA 2016, 100).

Fujiwara’s assessment that applying the label of post-secular to these various social engagement activities is problematic provides a helpful corrective to notions that there is a revival of religion in the Japanese public sphere. However, her criticism could go further. For example, Levi McLAUGHLIN (2016) has compared media coverage of religious groups after the 1995 earthquake in Kobe and the 2011 Tōhoku earthquake and points out how academics and members of the media are instrumental in portraying the recent work of interfaith chaplains more sympathetically as part of a projection of a new therapy-centered vision of religion. He also warns that these valorizing portrayals can blind us to the ways certain religious groups and discourses that do not conform to these therapeutic or ecumenical ideals are left out of this vision for bringing religion into the public sphere. At first glance, the work of interfaith chaplains suggests that religious groups are seeking to bring religion out of the closet to which it was confined in the wake of the 1995 sarin gas attacks. Yet the fact that interfaith chaplains have adopted a largely psychotherapeutic model of care to allay public concerns that they may have a religious agenda, and the fact that those who do not hew to ecumenical and secular expectations face marginalization, suggests that claiming the work of interfaith chaplains in disaster relief as evidence of growing post-secularity in Japan is premature.

Many of these same points also apply to the work of hospice chaplains. The work of spiritual care by hospice chaplains certainly appears post-secular in

that they represent a growing number of religious professionals entering secular medical spaces. But like interfaith chaplains working with disaster victims, spiritual care for patients is also intentionally framed in nonreligious terms. For example, the Vihāra priests were sensitive to the fact that their presence in medical settings would normally be thought of as inauspicious. For this reason, they deliberately left their Buddhist robes in their office for most of the day and projected a light-hearted image of their work, such as by pasting humorous caricatures of themselves on the wall outside their office.¹⁵ Chaplains emphasize the fact that they are not there to provide religious care for patients unless it is explicitly requested (FUKAYA and SHIBATA 2012).

Chaplains also feel the pressure to excise practices that do not conform to the ecumenical and psychotherapeutic ideals that permeate public discourse on spiritual care. For example, one Christian chaplain confided to me that although he could never say this out loud in the hospital or at a conference on spiritual care, at times he secretly prays for advanced cancer patients to be miraculously healed and will even ask patients if he can lay his hands on them while praying silently. Sometimes, he also wonders if the doctors are acting too swiftly to diagnose the patient as delirious if a patient claims to see someone in the room or hears voices (personal interview, 5 May 2015). In other words, this chaplain felt that if he seriously prayed for physical healing or suggested that an apparently delirious patient might actually be having a supernatural encounter, his medical and even religious colleagues would ostracize him. Accordingly, when chaplains publicly advocate for the importance of their work, they do so in terms that remain palatable to the medical spaces they work in.

Another problem with the notion of post-secularity in Japan is that not only are various agents utilizing religion for secular purposes, but that the religion versus secular binary can be constrictive (AMMERMAN 2013). For example, Jesse LEFEBVRE has shown how many secular Japanese actually assert nonreligiousness in order to signal religious normalcy and distance from religious behaviors that are considered “deviant, atypical, or extraordinary” (2015, 201). What most Japanese mean when they say they are “nonreligious,” is simply that they are not cognitively attached to a particular religious tradition, yet they may still engage in religious activities affectively and vicariously through the work of religious professionals who offer an eclectic range of religious services to them. In a similar vein, Isaac Gagne challenges the bifurcation of the religious and secular in Japan by showing how religious and ethical practices are not based on a distinct religious subjectivity but are rather rooted in “malleable repertoires of

15. By contrast, however, many Christian chaplains had no problem wearing a clerical collar or a nun's habit.

vitalistic, ‘spirit-focused’ empowerment” and self-improving practices that take place across private and public contexts (GAGNE 2013, 13).

Examining the practice of spiritual care offers similar insights. Although outwardly, religion plays a very marginal role in the daily care of patients, my personal interviews with Japanese chaplains reveal a more complicated picture. For instance, although chaplains readily admitted that religious care only constitutes a small part of their daily activities, they also pointed out that their work cannot be done by just anyone and that their religious identity remains integral to their work. They saw their role as important precisely because patients enjoy speaking with them, a religious professional, instead of with a clinical psychologist or nurse. For example, both Buddhist and Christian chaplains shared stories of patients who explained that they enjoyed their visits because they sensed “something unshakeable behind them” (*ushiro ni nanika yuraganai mono o kanjiru* 後ろに何か揺らがないものを感じる). Another Protestant chaplain suggested that their religious training also prepared them for engaging patients in conversation by forcing them to examine and meditate on their own views on life and death. A chaplain warned that without this theological or philosophical foundation, “your conversation can end up becoming superficial” (personal interview, 18 May 2015). Kubotera Toshiyuki, a former Christian chaplain and author of several textbooks on spiritual care, suggests that although spiritual pain is often expressed in terms of psychological stress, beneath the surface exist deeper philosophical doubts, religious questions, and a desire for relief (*kyūsai* 救済) that chaplains are better trained to deal with (KUBOTERA 2005). Another study of Christian chaplains in Japan reported that although chaplains saw pressuring patients to adopt their belief system as antithetical to the nature of their work, many admitted that it was impossible to completely bracket their own religious views when facing patients who seek out religious or existential guidance (FUKAYA and SHIBATA 2012).

The public and private faces of spiritual care in the hospice ward are part of what makes defining spiritual care so problematic. On the one hand chaplains are aware that if their work is to become mainstream, they must articulate their roles in psychotherapeutic terms since many Japanese—including their medical colleagues—harbor suspicions that a religious professional might have a religious agenda. Consequently, chaplains are careful to present their work to patients and medical colleagues as not primarily religious in character. Yet at the same time, when asked to distinguish their skill set from other psychotherapeutic professions, chaplains admit that their religious training and identity invariably forms the backbone of their work. This tension could be seen, for example, when I accompanied a Vihāra priest as he gave a lecture on the topic of spiritual care to medical staff at a large hospital nearby. One of the first questions from the audience was, “How is the role of a chaplain different from that of a clinical psychologist?” In

light of the ways in which the Vihāra priest's presentation emphasized the non-religious aspects of their daily work, it seemed natural to ask what made their religious training even necessary.¹⁶ In his reply, the Vihāra priest suggested that one reason their religious expertise was necessary was in case there were patients who might "seek this out" (*motomerareta toki* 求められた時).

Other chaplains explain the differences between clinical psychology and spiritual care by pointing out that psychologists are fundamentally concerned with treating the patient using specific counseling therapies that are part of mainstream medicine. In contrast, a chaplain is there to simply listen and empathize, perhaps even to cry with the patient. For instance, a Buddhist chaplain at a hospital in Western Japan was asked by her supervisors to pursue additional certification as a clinical psychologist even as she continued her work of spiritual care. They explained to her that having a clinical psychologist on staff would help the hospital accrue more "points" that were used in hospital rankings since chaplains do not count. But even after she became certified as a clinical psychologist, she did not observe much change in her work. From time to time she did draw on her psychological training when she thought a patient might be suffering from depression or a mental illness, but otherwise, her approach to work remained the same. This suggests that she did not see her clinical psychology training as adding anything significant to the work of spiritual care; in her mind they represented two different perspectives that informed two different roles. Yet even while she was personally aware of these differences, she also noted that most of the medical staff had difficulty distinguishing between psychological and spiritual care (personal interview, 2 July 2015).

Conclusion

This article has sought to emphasize the key role supportive care plays in the practice of spiritual care in light of the fact that many Japanese hospice patients claim to be nonreligious. Spiritual caregivers in Japan often rely on first seeking to develop a relationship (*kankeisei* 関係性) with the patient in the hope that after a level of trust has been established, some patients may feel more comfortable sharing their religious or existential concerns. Or, in light of the fact that many patients appear disinclined or uninterested in bringing up such concerns with hospice workers in the first place, spiritual caregivers may rely on simply showing patients how much they are valued. Either way, supportive care plays an important role in fostering an environment where patients feel comfortable and

16. The diminishing religious role of chaplains is not absent in Western hospices either, due to the growing number of nonreligious patients (VANDECREEK 1999; BROWN 2005). For more on the difficulty of distinguishing nonreligious forms of spiritual care from psychological care, see WALTER (1997).

cared for.¹⁷ Supportive care can also be claimed as particularly suitable for contemporary Japanese, who typically express less concern over religious questions of faith or belief.¹⁸ Furthermore, though spiritual care is often contrasted with physical or psychological care, the actual embodied practice of spiritual care in Japan lies in tension with the impulse to distinguish between spiritual and physical or psychosocial forms of pain. Hospice staff routinely offer spiritual care in the margins of other forms of care, and chaplains often use social events and activities such as tea gatherings and gardening as a conduit for helping patients share and work through the anxieties they may face.¹⁹

The practice of spiritual care also shows the difficulty measuring “post-secularity” in Japan. Valorizing a vision of religious social engagement in Japan glosses over questions of how the work of chaplains is shaped by medical practices or why certain discourses are celebrated or silenced in the practice of spiritual care. While chaplains privately indicate the important role that religion plays in their work, they also publicly downplay their religious expertise, or frame it in the ambiguous terminology of “spirituality” to secure the trust of fellow medical workers and their patients. In order to maintain this trust, discourse on healing miracles or other supernatural events in the hospice are oftentimes excluded from discussions of spiritual care. In other words, chaplains are caught in a complex web of expectations about what their role should be. These include expectations by doctors and nurses that they will not abuse their position in the medical wards to push their religious views on patients; expectations by religious scholars and the media that spiritual care 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 professionals themselves who see spiritual care as an opportunity for social engagement with a Japanese public that increasingly identifies itself as nonreligious. For Buddhists in particular, engaging in hospice care has the potential to combat long-standing negative stereotypes about their work as confined to funerary and memorial rites by expanding their expertise to care from those already dead to those who are dying. Sympathetic and celebratory portrayals of these endeavors

17. Japanese psychiatrists are also known to emphasize nonverbal approaches with clients by using sandbox, clay sculpture, and especially box garden therapy (*hakoniwa*) to help Japanese express their feelings (HOHENSIL, AMUNDSON, and NILES 2013, 102).

18. Clearly, many deeply religious Buddhist, Christian, and New Religious adherents would challenge this generalization. However, most chaplains I spoke with agreed that the majority of patients expressed little concern over “faith” in a particular religious tradition. For similar claims see READER (1991, 15–20); READER and TANABE (1998, 130); and TRAPHAGAN (2004, 177).

19. For instance, one nurse described how she would use foot massages as a way to help patients open up. Likewise, chaplains rely on events like tea gatherings to engage patients in conversation and create further opportunities for sharing their spiritual concerns.

in the mass media and by scholars of religion also help bring a measure of social capital to religious institutions (KASAI and ITAI 2013).

Historically, religion in Japan provided a cosmological framework and a ritual repertoire for the end of life that helped assure the dying person of an auspicious rebirth, or escape from *samsara* altogether. However, most contemporary Japanese hospice patients only rarely seek out these religious assurances. As a result chaplains are expected to draw on a very different set of practices that align more closely to an ecumenical and psychotherapeutic model of care by which discourse on spiritual care is legitimized in secular spaces. Looking at the actual practice of spiritual care helps us see some of the ways chaplains both draw on and also resist these models of care. It also reveals how religion is both marshaled and marginalized by hospice workers in ways that are deeply implicated in the medical spaces in which spiritual care takes place, the continued suspicion or disinterest Japanese hold toward religion, and efforts by religious groups, scholars, and the media to promote a “healthy” image of religion in Japanese society.

REFERENCES

- AMMERMAN, Nancy T.
 2013 Spiritual but not religious? Beyond binary choices in the study of religion. *Journal for the Scientific Study of Religion* 52: 258–78.
doi.org/10.1111/jssr.12024
- ANDŌ Yasunori 安藤泰至
 2008 “Supirichuariti” gainen no saikō: Supirichuariti wa reiteki sekaikan o zen-tei to suruka? 「スピリチュアリティ」概念の再考—スピリチュアリティは靈的世界観を前提とするか? *Shiseigaku nenpō* 4 (March): 5–25.
 2010 Seishin bunseki to supirichuariti 精神分析とスピリチュアリティ. In *Supirichuariti no shūkyōshi* スピリチュアリティの宗教史, Tsuruoka Yoshio 鶴岡賀雄 and Fukasawa Hidetaka 深澤英隆, eds., 373–97. Tokyo: Riton.
- BAFFELLI, Erica, and Ian READER
 2012 Impact and ramifications: The aftermath of the Aum affair in the Japanese religious context. *Japanese Journal of Religious Studies* 39: 1–28.
dx.doi.org/10.18874/jjrs.39.1.2012.1-28
- BROWN, Carlton F.
 2005 Old religion, new spirituality, and health care. In *Spirituality and Health: Multidisciplinary Explorations*, Augustine Meier, Thomas St. James O’Connor, and Peter VanKatwyk, eds., 191–209. Waterloo, Ontario: Wilfrid Laurier University Press.

FUJIWARA, Satoko

- 2016 Secularity and post-secularity in Japan: Japanese scholars' responses. *Journal of Religion in Japan* 5: 93–110. doi.org/10.1163/22118349-00502007

FUJIYAMA Midori 藤山みどり

- 2012 “Rinshō shūkyōshi” no kanōsei o shakai no nizu kara saguru: “Rinshō shūkyōshi” o meguru kōsatsu: Zenpen 「臨床宗教師」の可能性を社会のニーズから探る—「臨床宗教師」をめぐる考察—前編. Center for Information on Religion. www.circam.jp/reports/o2/detail/id=3177 (accessed 10 July 2015).

FUKAYA Mie 深谷美枝 and SHIBATA Minoru 柴田 実

- 2012 Supirichuaru kea to enjōsha no shūkyōsei ni tsuite no jisshōteki kenkyū スピリチュアルケアと援助者の宗教性についての実証的研究. *Meiji Gakuin Daigaku shakaigakubu fuzoku kenkyūjo nenpō* 45 (March): 43–57.

GAGNE, Isaac Thomas

- 2013 Private Religion and Public Morality: Understanding Cultural Secularism in Late Capitalist Japan. PhD dissertation, Yale University.

HANAOKA Naoki 花岡直樹

- 2012 Sei to shi no imi o sasaeru: Shūkyōteki ni kakawatta 3 jirei 生と死の意味を支える—宗教的に関わった3事例. *Kanwa kea* 22: 229–32.

HAYASHI, Moichiro

- 2012 “True regard”: Shifting to the patient’s standpoint of suffering in a Buddhist hospital. In *Buddhist Care for the Dying and Bereaved*, Jonathan S. Watts and Yoshiharu Tomatsu, eds., 57–73. Boston: Wisdom Publications.

HAYASHI Yoshihiro 林 貴啓

- 2011 *Toi toshite no supirichuariti: “Shūkyō naki jidai” ni seishi o kataru* 問いとしてのスピリチュアリティー—「宗教なき時代」に生死を語る. Kyoto: Kyoto Daigaku Gakujutsu Shuppankai.

HERMAN, Jonathan R.

- 2014 The spiritual illusion: Constructive steps towards rectification and redescription. *Method and Theory in the Study of Religion* 26: 159–82. doi.org/10.1163/15700682-12341264

HOHENSIL, Thomas H., Norman E. AMUNDSON, and Spencer G. NILES, eds.

- 2013 *Counseling Around the World: An International Handbook*. Alexandria, VA: American Counseling Association.

HORIE, Norichika

- 2009 Spirituality and the spiritual in Japan: Translation and transformation. *Journal of Alternative Spiritualities and New Age Studies* 5. www.open.ac.uk/Arts/jasanas/ (accessed 13 August 2013).

HPCJ (Hospice Palliative Care Japan)

- 2017 Kanwa kea byōtō nyūin todokede juri shisetsu ichiran 緩和ケア病棟入院届出受理施設一覧. www.hpcj.org/what/pcu_list.pdf (accessed 8 May 2017).

IGARASHI Naoko 五十嵐尚子 and MIYASHITA Mitsunori 宮下光令

- 2017 Dētā de miru Nihon no kanwa kea no genjō データで見る日本の緩和ケアの現状. In *Hosupisu kanwa kea hakusho 2017: Shōni kanwa kea no genjō to tenbō* ホスピス緩和ケア白書2017—小児緩和ケアの現状と展望, Shima Yasuo 志真泰夫 et al., eds., 78–107. Tokyo: Seikaisha.

JHPC (Japan Hospice Palliative Care Foundation)

- 2017 Hosupisu kanwa kea ni kansuru ishiki chōsa (2006–2012) ホスピス緩和ケアに関する意識調査 (2006–2012). www.hospat.org/research-top.html (accessed 31 March 2017).

JSSC (Japan Society for Spiritual Care)

- 2017 Supirichuaru keashi “nintei” shikaku shutokusha ichiran スピリチュアルケア師「認定」資格取得者一覧. www.spiritualcare.jp/mwbpwp/wp-content/uploads/nintei_2016.pdf (accessed 8 May 2017).

Kanwa Kea 緩和ケア

- 2005 Supirichuaru pein: Inochi o sasaeru kea スピリチュアルペイン—いのちを支えるケア. No. 15, special issue.
- 2009 Supirichuaru kea no chōryū: Kenkyū, shisō to kea o tsunagu スピリチュアルケアの潮流—研究・思想とケアをつなぐ. No. 19, special issue.
- 2012 Ima, aratameteshūkyōtekieka o toraenaosu 今、改めて宗教的ケアを捉え直す. No. 22, special issue.

KASAI Kenta 葛西健太 and ITAI Masanari 板井正齊, eds.

- 2013 *Kea toshite no shūkyō* ケアとしての宗教. Tokyo: Akashi Shoten.

KASHIO Naoki 樫尾直樹

- 2010 *Supirichuaru ite kakumei: Gendai reisei bunka to hirakareta shūkyō no kanōsei* スピリチュアリティ革命—現代霊性文化と開かれた宗教の可能性. Tokyo: Shunjūsha.
- 2012 Supirichuaru ite to wa nani ka? Gendai bunka no reiseiteki shosō スピリチュアリティとは何か? 現代文化の霊性的諸相. In *Bunka to reisei* 文化と霊性, ed. Kashio Naoki, 1–32. Tokyo: Keio Gijuku Daigaku Shuppan.

KISALA, Robert

- 1999 Asian values survey. *Bulletin of the Nanzan Institute for Religion and Culture* 23: 59–73. nirc.nanzan-u.ac.jp/nfile/1914 (accessed 14 March 2017).

KIYOTA Naoto 清田直人

- 2015 Hosupisu kanwa kea ni okeru supirichuarukea no teigi ホスピス緩和ケアにおけるスピリチュアルケアの定義. Presented at the Japan Society for Spiritual Care Annual Meeting, Kōyasan University, Wakayama, Japan. 12 September.

KOKUSAI SHŪKYŌ KENKYŪJO 国際宗教研究所, ed.

- 2012 Daisaigai to bunmei no tenkan 大災害と文明の転換. *Gendai shūkyō 2012 tokushū* 現代宗教 2012 特集. Tokyo: Akiyama Shoten.

KONISHI Tatsuya 小西達也

- 2013 Chapuren to iu senmonshoku no tachiba kara supirichuaru kea o kangaeru チャプレンと言う専門職の立場からスピリチュアルケアを考える. In *Supirichuaru kea no jitsugen ni mukete: "Dai 18 kai Nihon Rinshō Gakkai no torikumi"* スピリチュアルケアの実現に向けて「第18回日本臨床学会大会」の取り組み, ed. Kubotera Toshiyuki, 65–85. Saitama: Seigakuin Daigaku Shuppankai.

KUBOTERA Toshiyuki 窪寺俊之

- 2005 Supirichuaru pein no honshitsu to kea no hōhō スピリチュアルペインの本質とケアの方法. *Kanwa kea* 15: 391–95.

LEFEBVRE, Jesse

- 2015 Christian wedding ceremonies: “Nonreligiousness” in contemporary Japan. *Japanese Journal of Religious Studies* 42: 185–203.
doi.org/10.18874/jjrs.42.2.2015.185-203

MARTIN, Craig

- 2014 *Capitalizing Religion: Ideology and the Opiate of the Bourgeoisie*. London: Bloomsbury.

MCLAUGHLIN, Levi

- 2016 Hard lessons learned: Tracking changes in media presentations of religious aid mobilization after the 1995 and 2011 disasters in Japan. *Asian Ethnology* 75: 105–37. doi.org/10.18874%2Fae.75.1.05

MITCHELL, Kerry A.

- 2011 The politics of spirituality: Liberalizing the definition of religion. In *Secularism and Religion Making*, Markus Dressler and Arvind-Pal S. Mandair, eds., 125–40. Oxford: Oxford University Press.

MURASE Masaaki 村瀬正光 et al.

- 2012 Kanwa kea byōtō ni okeru shūkyōka no katsudō no genjō ni tsuite no shitsuteki kenkyū 緩和ケア病棟における宗教家の活動の現状についての質的研究. www.hospat.org/assets/templates/hospat/pdf/report_2012/2012-c1.pdf (accessed 7 August 2016).

NATIONAL INSTITUTE OF POPULATION AND SOCIAL SECURITY RESEARCH

- 2017 Nihon no shōrai suihei jinkō (Heisei 29 nen suihei) 日本の将来推計人口(平成29年推計). www.ipss.go.jp/pp-zenkoku/j/zenkoku2017/pp29_gaiyoyu.pdf (accessed 11 May 2017).

NIHON HŌSŌ KYŌKAI 日本放送協会 (NHK)

- 2016 “Odayaka na shi” o mukaetai: Iryō to shūkyō aratana kokoromi 「穏やかな死」を迎えたい—医療と宗教新たな試み. *Kurōzuappu gendai*, no. 3853. 25 August.

PUCHALSKI, Christine M.

- 2012 Restorative medicine. In *Oxford Textbook of Spirituality in Healthcare*, Mark Cobb, Christina M. Puchalski, and Bruce Rumbold, eds., 197–210. Oxford: Oxford University Press.

READER, Ian

- 1991 *Religion in Contemporary Japan*. Honolulu: University of Hawai'i Press.
- 2012 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: 7–36. doi.org/10.1163/221183412x628370
- 2013 Review of Inken Prohl and John Nelson, eds. *Handbook of Contemporary Japanese Religions*. *Japanese Journal of Religious Studies* 40: 377–82.

READER, Ian, and George J. TANABE, Jr.

- 1998 *Practically Religious: Worldly Benefits and the Common Religion of Japan*. Honolulu: University of Hawai'i Press.

SAKURAI Yoshihide 櫻井義秀

- 2009 *Rei to kane: Supirichuaru bijinesu no kōzō* 霊と金—スピリチュアル・ビジネスの構造. Tokyo: Shinchosha.

SHIMAZONO Susumu 島蘭進

- 2007 *Supirichuariti no kōryū: Shinreisei bunka to sono shūhen* スピリチュアリテイの興隆—新霊性文化とその周辺. Tokyo: Iwanami Shoten.
- 2012 *Gendai shūkyō to supirichuariti* 現代宗教とスピリチュアリテイ. Tokyo: Kōbundō.

SHIMAZONO Susumu, and Tim GRAF

- 2012 The rise of the new spirituality. In *Handbook of Contemporary Japanese Religions*, Inken Prohl and John Nelson, eds., 459–85. Leiden: Brill.

SUPIRICHUARU KEA JIREI KENTŌSHŪ SAKUSEI GURŪPU, ed.

- 2011 *Supirichuaru kea jirei kentōshū: Taiō ni konnan o kanjita bamen to sono imi* スピリチュアルケア事例検討集—対応に困難を感じた場面とその意味 Osaka: Japan Hospice Palliative Care Foundation.

TAKAHASHI, Hara

- 2016 The ghosts of tsunami dead and *kokoro no kea* in Japan's religious landscape. *Journal of Religion in Japan* 5: 176–98.
doi.org/10.1163/22118349-00502002

TAMIYA Masashi 田宮仁

- 1988 Bukkyō fukushi to taminaru kea: Bihāra kōsō o chūshin ni 仏教福祉とターミナルケア—ピハラー構想を中心に. In *Inochi no yasuragi: Hosupisu o megutte* いのちの安らぎ—ホスピスをめぐって, ed. Iryō to Shūkyō o Kan-gaerukai 医療と宗教を考える会, 103–35. Kyoto: Dōhōsha Shuppan.

TANIDA Noritoshi 谷田憲俊

- 2011 *Supirichuaru kea: Komyunikēshon kara no tenkai* スピリチュアルケア—コミュニケーションからの展開. In *Taiwa, komyunikēshon kara manabu*

supirichuaru kea: Kotoba to monogatari no jissen 対話・コミュニケーションから学ぶスピリチュアルケア—言葉と物語の実践, Tanida Noritoshi, Ōshita Daiken 大下大圓, and Itō Takaaki 伊藤高章, eds., 2–11. Tokyo: Shindan to Chiryōsha.

TRAPHAGAN, John W.

2004 *The Practice of Concern: Ritual, Well-Being, and Aging in Rural Japan*. Durham, NC: Carolina Academic Press.

VANDECREEK, Larry

1999 Professional chaplaincy: An absent profession? *Journal of Pastoral Care* 53: 417–32.

WALTER, Tony

1997 The ideology and organization of spiritual care: Three approaches. *Palliative Medicine* 11: 21–30. doi.org/10.1177/026921639701100103

WOOD, Matthew

2010 The sociology of spirituality: Reflections on a problematic endeavor. In *The New Blackwell Companion to the Sociology of Religion*, ed. Bryan S. Turner, 267–85. West Sussex: Wiley-Blackwell.

