Buddhist spiritual caregivers in Japan

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Introduction

In Japan, the term ‘spiritual care’ has appeared in the academic world since the late 1990s (Suzuki and Nakamura 2008). One of the earliest references to spiritual care was made by Toshiyuki Kubotera, who stated,

If spirituality is the concern for the transcendent, the desire for uniting with it, and a search for the meaning or aim of self-existence, it comes closer to the concept of ‘religiosity’ or ‘religious mind.’ . . . It is necessary to establish a proper system of assistance in this aspect in clinical settings. Especially in the medical treatment of terminal patients suffering with cancer or other incurable diseases, the possibility of spiritual care (supirichuaru kea) should be adequately considered and put into practice.

(Kubotera 1996: 190–191)²

Notably, Kubotera did not translate the term ‘spiritual care’ into Japanese in this sentence but rather rendered it in katakana syllabary.

To this day, this Japanized English phrase remains the standard terminology and ‘spiritual care’ textbooks for clinical workers come out almost every year. In one textbook for nurses, Hisayuki Murata, one of the influential authors of this field, writes,

Religious care is important. . . . However, in our country today, most of the patients, their family, and medical professionals don’t want religious professionals to intervene in their treatment. It can be said that there are few chances where religious care soothes patients’ spiritual pain. Hence, Japan requires a kind of spiritual care that is not necessarily religious.

(Murata 2012: 4)

This distinction between ‘religious care’ and ‘spiritual care’ is a common strategy in Japan. The former is largely something provided by religious professionals by way of specific religious rites on the basis of religious doctrine, while the latter is by various people using various
methods: playing music, for example. This distinction is necessary in the secular atmosphere of Japanese society so that religion be excluded or hidden from public spaces. Murata admits both ‘religious care’ and ‘spiritual care’ can serve to soothe patients’ spiritual pain, but he suggests that the former does not fit the secular framework of Japanese hospital care and patients do not want it, either. On the other hand, the latter is thought to be what laypeople, including nurses and doctors, can or should provide. This has been one typical attitude of medical professionals toward spiritual care in Japan. That is, spiritual care can be provided without any reference to religion.

The exclusion of religion from Japanese hospitals is well-illustrated by Yoshiharu Tomatsu’s description of ‘a strong wall between premortem and postmortem worlds,’ with the former dominated by medical professionals and the latter by religious professionals, generally Buddhist priests, who conduct funerals (Tomatsu 2012: 39). Buddhist priests have been regarded not as caregivers for the living but for the dead, their practice being criticized as sōshiki Bukkyō (funeral Buddhism). Sōshiki Bukkyō has long been a term with which to criticize Japanese temple Buddhism for being a mere funeral industry centring around ancestor worship, in contrast with kyōri Bukkyō (doctrinal Buddhism), that is, moral education based on sutras.

The climate changed with ‘3.11,’ the Great Tohoku Earthquake and concomitant tsunami of 11 March 2011, when many Buddhist priests took part in supporting activities in the disaster areas. Among their activities, their ‘active listening’ (keichō) was highly reputed. It is often pointed out that people felt encouraged by the presence of priests who came to listen to them. A home hospice doctor, Takeshi Okabe, reported,

> When I went to the disaster areas, people were actually going to nearby young priests with shaved heads rather than to me, a doctor. Listening to their conversation, I found people telling them completely different things from what they told us. Religious professionals, I think, are those to whom people can disclose what they have deep in their souls.

(Okabe 2012: 3)

Insight into this ability of religious professionals, Buddhist priests among others, led to the birth of a project to train them to be interfaith chaplains. Rinshō shūkyō-shi, the Japanese phrase coined for this new position, literally means ‘clinical religious professional,’ but the founders of these training programmes consider it equivalent to the English term ‘interfaith chaplain.’ They chose the word ‘chaplain’ because the rinshō shūkyō-shi is expected to fulfil the same role as chaplains in the United States, typically those in hospitals. The choice of ‘interfaith’ instead of ‘multifaith’ is because chaplaincy work should be based on interreligious cooperation to avoid being suspected of proselytism, which is important in the secular society of Japan. Most importantly, as caregivers, rinshō shūkyō-shi have to take care of people of different faiths as well as the majority with no particular faith.

Following the first training programme for rinshō shūkyō-shi at Tohoku University, launched in 2012, one after another university followed suit, almost all of which have Buddhist affiliations. Despite their religious affiliations, these training programmes aimed to teach Buddhist priests to provide ‘spiritual care,’ not ‘religious care.’ Since ‘spiritual care’ is thought to be a method that can be applied in secular ways, it was considered an instrument to help Buddhist priests make their way into public spaces, such as hospitals. It is not that they wanted to bring Buddhism to clinical fields in a secular guise but that they find ‘spiritual care,’ that is, to listen to people in suffering, something that conforms with Buddhist ideals.
In this chapter, I first sketch the social context of Japan that prepared Buddhists to come into the clinical world, then take up writings by three influential Buddhist instructors who are engaged in the training programmes for spiritual caregivers, and finally provide an example of one particular Buddhist priest working as a rinshō shūkyō-shi. This illustrates how Japanese Buddhists have endeavoured to transplant ‘spiritual care’ into Japanese soil.

**Buddhism and the hospice movement in Japan**

‘Hyper-aged’ (chōkōrei) and ‘numerous deaths’ (tashi) have been commonplace words to describe twenty-first century Japanese society, where twenty-eight per cent of the population was sixty-five or older in 2019. The Japanese government issued legal acts and guidelines in the 2000s to cope with newly-emerging problems such as the Long-Term Care Insurance Act (2000), Cancer Control Act (2006), the Basic Plan to Promote Cancer Control Programmes (2007) and Guidelines on the Decision-making Process for Medical and Nursing Care at the Last Stage of Life (2007). How to prepare for death, in terms of ‘advanced care planning’ or ‘end of life care,’ has become one of the Japanese population’s great concerns.

The Vihara movement is one example of a Buddhist response to this problem. Vihara is a Sanskrit term that means ‘a temple’ or ‘a place of rest.’ Some Buddhist hospice wards in Japan have adopted it as the name of their facilities. The rise of the hospice movement in Japan can be traced back to the 1970s, when the ‘aging society’ started, when over seven per cent of the population was aged sixty-five or older, and the deaths in hospitals outnumbered those at home for the first time in 1977. Christian organizations took the lead in founding hospice care units in their hospitals. In the next forty years, the number of such units reached 300 and, in most cases, Christian pastors or nuns served as chaplains. It was in 1990 that the first Buddhist hospice care ward—called ‘Vihara’—was founded in Nagaoka Nishi Hospital in Niigata Prefecture. Several other Buddhist facilities appeared following this, though limited in number (Taniyama 2014).

Accordingly, some Buddhist-affiliated universities founded training courses for Buddhist care workers. Bukkyō University in Kyoto opened a one-year graduate course for Buddhist nursing in 1993, which closed in 2006. A Department of Spiritual Care was founded at Kōyasan University in 2006, but stopped admission of students in 2010. An academic association called the Japan Association for Buddhist Nursing and Vihara Studies (Nihon Bukkyō Kango Bihāra Gakkai) was founded in 2004.

‘Funeral Buddhism’ and contemporary challenges of ‘temple Buddhism’

The Vihara movement was a response to long-standing criticisms of the aforementioned ‘funeral Buddhism’ (Taniyama 2012: 76–77). While Buddhist priests in Japan have enjoyed the prosperity of funeral-related business, they have also experienced guilt or frustration because they suspected that their practices deviate from legitimate Buddhist teaching and do not enrich people’s lives. But prospects for the funeral business are not so bright for temples in light of twenty-first century Japan’s population decline and shifting trends in funerary practice. In the 2010s, one after another bestselling book predicted a dark future for funeral Buddhism. One of them, Hiromi Shimada’s *Funerals are Unnecessary* (Sōshiki wa iranai), recommends a simple cremation without costly funeral services (Shimada 2010). Another, Hidenori Ukai’s *Extinction of Temples* (Jiin Shōmetsu), describes how difficult it is to make one’s living by running a temple, especially in rural, less populated areas (Ukai 2015).
In addition to these critical analyses of the Japanese Buddhist funeral industry, there have also been arguments for the possibility of revitalizing temple Buddhism. Authors like Noriyuki Ueda (2004), apparently stimulated by the international ‘engaged Buddhism’ movement, which became widely known in Japan around 2000, highly evaluates the function of local temples that serve as community centres, and funeral Buddhism as a traditional way of fostering the grief work of the bereaved. These writings empowered Japanese Buddhist priests, who argued that Buddhism has rich resources for priests to engage Japanese society. A number of socially-engaged Buddhist movements emerged in the 2000s (Watts and Okano 2012). In this period, it was not their own tradition of doctrinal Buddhism but rather engaged Buddhism from overseas that functioned as a mirror in which Japanese Buddhists looked in search of a new identity (Takahashi 2021).

‘Spiritual care’ and the role of religion in contemporary Japanese society

This was the period when Kubotera and others began introducing ‘spiritual care’ to Japanese readers and, incidentally, when news of the World Health Organization’s (WHO) discussion to revise the definition of health by inserting the term ‘spiritual’ reached Japan (see Toniol, this volume). Soon the Health Science Council of the Ministry of Health and Welfare (Kōseishō) had a series of meetings to discuss the subject of spiritual care (Tanatsugu 2007). A number of religious studies scholars and therapeutic practitioners reacted favourably to this development, and engaged in discourse regarding the reconsideration of the role of religion in contemporary society.

As previously mentioned, the 2011 Tohoku earthquake and tsunami made Japanese Buddhist priests further conscious of their role in contemporary society (Taniyama 2014, Takahashi 2016). Newspapers and TV programmes frequently reported the volunteer work of Buddhist priests, like when they visited temporary housing units and spoke with evacuees. In such reports, the term ‘kokoro no kea’ (care of the heart-mind) was often used to describe how their presence encouraged people in grief. ‘Kokoro no kea’ had been widely used since the 1990s, especially after the Great Hanshin-Awaji Earthquake of 1995. Though, in the narrow sense, this term literally means ‘mental care,’ such as the treatment of PTSD, it has gradually been applied to a variety of supportive actions related to grief care offered by those, including Buddhist volunteers, and not limited to those in the clinical professionals (Nakai 2012). The experience of the two great disasters gave Japanese Buddhist priests a chance to question their identity. What could they do as Buddhists to help suffering people? What kind of professionals are they? The notion of kokoro no kea by way of ‘active listening’ (keichō) gave them a clue for how to join in the care team in varieties of settings, even in public spaces where religious acts are usually prohibited. In some cases, even funeral Buddhism has been rebranded as kokoro no kea, rehabilitating its negative image as an opportunity to care for the living by taking care of the dead.

As such, a number of Buddhist priests welcomed Tohoku University’s 2012 founding of a Department of Practical Religious Studies and its course to train religious professionals, whether Buddhist, Christian, or Shinto, as rinshō shūkyō-shi (interfaith chaplains). The role of rinshō shūkyō-shi is designed to help religious professionals provide kokoro no kea, particularly spiritual care, in public spaces. At this time, spiritual care appeared like a passport allowing Japanese religious professionals, especially Buddhist priests, to enter public spaces. What type of spiritual care best suited the Japanese context was, however, was yet to be determined.
Four factors in the development of Buddhist spiritual care in Japan

In the roughly twenty years since the 1998 discussion of spiritual health by the WHO, Japanese Buddhists began to accept their role as spiritual caregivers under the guidance of forerunners like Kubotera. In the last two decades, four factors or contexts inspired Japanese Buddhists in the formation of Buddhist spiritual care in Japan: A) Western theories of psychology, thanatology, psychotherapy, grief care, spiritual care, pastoral care, and chaplaincy; B) re-evaluation of and stimulation by overseas Buddhism, including Theravada Buddhism, Vipassana meditation, the mindfulness movement (see Hickey, this volume), and engaged Buddhism; C) Japanese culture, including folk practices related to funeral Buddhism, centred around ancestor worship; and D) the context of contemporary Japanese society, where the population is hyper-aged, basically nonreligious, and increasingly secular, and temples are said to be on the verge of extinction. In this context, especially after the ‘Great Disasters’ of 2011, there has been a trend for Buddhist priests and secular professionals to collaborate with each other as a team. Spiritual care could be a powerful skill that allows Buddhist priests to be welcomed into public spaces as professional caregivers.

The following sections take up three Buddhist authors who have attempted to transplant spiritual care to Japanese soil: Daien Ōshita, Wimara Inoue, and Yōzō Taniyama. Though there is still no solid consensus as to what spiritual care is, these three are among the most influential voices trying to give substance to that concept in a Buddhist fashion. These authors share four common features: 1) they are, or at least used to be, Buddhist priests; 2) they use the term ‘spiritual care’ in their theory or practice; 3) they supervise training programmes for Buddhist spiritual caregivers; and 4) they are under the influence of Toshiyuki Kubotera's understanding of spiritual care. Thus, before turning to these three figures’ Buddhist spiritual care discourses, I will first address Kubotera’s work.

Toshiyuki Kubotera 窪寺俊之

Toshiyuki Kubotera (b. 1939), a Christian pastor (Free Methodist), is a pioneer in introducing chaplaincy and spiritual care in Japan. Though he started his career as a Rogerian counsellor (that is, based on the person-centred therapy of Carl Rogers), he received training and worked as a chaplain in the United States. After returning to Japan, he became a professor at several universities, as well as serving as a hospital chaplain and a pastoral counsellor. In 2005, Kubotera became the founding supervisor for the Professional Association for Spiritual Care and Health (PASCH, Rinshō Supirichuaru Kea Kyōkai). Kubotera and his colleagues (including Taniyama), adapted US methods for chaplaincy training (Clinical Pastoral Education, see Cadge and Skaggs, this volume) to launch a chaplaincy training programme in Japan. Discourse on spiritual care in Japan began to move in an interfaith and ecumenical direction, quite different from previous attempts in the hospice movement, whether Christian or Buddhist.

Kubotera has written a number of books introducing spiritual care to Japanese students. For Kubotera, spirituality awakens in the face of crisis. The spiritual subject desires two types of infinity: (an) exterior transcendent other(s), typically God or god(s), and the ‘interior ultimate self’ (naimen no kyūkyokuteki jiko). Therefore, the goal of spiritual care is to help one fulfil this desire for infinity. He explains,

Spiritual care is indispensable to improve patients’ quality of life, as well as palliate their physical, mental and social pain, especially when they question, in the face of
Spiritual care is to help find new, extra-human meaning and realize a new ‘framework of being’ or ‘self-identity,’ in an invisible world or in the sphere of emotion and faith, which we tend to forget in our daily life.

(Kubotera 2008: 58)

Kubotera’s emphasis on transcendence reflects his Christian career, as Japanese deities (kami) or Buddhas (hotoke) are not necessarily felt to be transcendent in the sense of ‘desire for an external infinity.’ But Kubotera’s understanding of spirituality and spiritual care has been foundational for his followers, including the three aforementioned Buddhists. The question, then, is how to utilize Buddhist resources to support the fulfilment of one’s desire either for the transcendent being or for the inner ultimate self.

Regarding the four factors/contexts for Japanese spiritual care mentioned earlier, Kubotera’s concerns can be situated between A) Western psychotherapy and D) contemporary Japanese society, whereas Daion Ōshita’s lie between B) overseas Buddhism and C) traditional Japanese culture, Inoue’s between A and B, and Taniyama’s between C and D. Of course, they all overlap and interrelate with each other to some extent.

Daien Ōshita 大下大圓

Daien Ōshita (b. 1954) is the head priest (jūshoku) of Hida Senkōji, a Kōyasan Shingon temple in Gifu prefecture. In 2004, he founded the Nihon Spiritual Care Worker Association (Nihon Supirichuaru Kea Wākā Kyōkai), a non-profit organization that was among the first Buddhist-oriented organizations for training spiritual care providers, which include not only Buddhists priests but also laypeople, typically nurses.

Ōshita’s Spiritual Care: Healing and Healed (Iyashi Iyasareru Supirichuaruaru Kea, 2005) follows Kubotera’s explanation of spiritual care before extracting additional lessons about spiritual care from Buddhist sutras. Ōshita took Kubotera’s view of spirituality and added a horizontal dimension, implying that he places importance on one’s social relations in addition to transcendent beings and one’s inner life.

In this book’s postscript, Ōshita wrote, ‘I am challenged with the task of giving the foreign term “spiritual care” a firm basis in Japan, making its role and meaning clear in a land where Buddhist culture has been nurtured’ (Ōshita 2005: 270). As this illustrates, ‘Japan’ is crucial for Ōshita.

Ōshita plans to elaborate traditional Japanese Buddhist practice, including the aforementioned funeral Buddhism, as effective methods of care, taking advantage of his position as the chief priest of a local temple. He proposes developing desirable ways to conduct funerals from the viewpoint of end of life support and grief care (Ōshita 2005: 158ff). For example, he made various modifications in a funeral he conducted, according to the requests of the bereaved family. A close friend emceed the ceremony; they made colourful flower arrangements, placed paintings by the deceased behind the coffin, and family members spoke their messages to the dead. These practices are different from a conventional Buddhist funeral, where flowers are all white, a message by a family member is read to the participants, and so on.

Another of Ōshita’s innovations is to have caregivers, such as doctors, nurses, or home helpers, attend a ‘QOL (Quality of Life) Refresh Seminar’ or ‘view of life and death (shiseikan) workshop’ to help prevent burnout syndrome. In the workshop, participants engage in talking sessions and roleplaying, as well as meditation and bodywork. Quite unique among the
sessions of Ōshita’s workshop is the simulation of the forty-nine-day afterlife before rebirth or before becoming a Buddha (jōbutsu). Participants simulating the dead have to walk through a dark corridor until they reach a bright room, where they are warmly welcomed by those who are already there, waiting for them. According to Ōshita, this seminar is an original method he developed, integrating aspects from various sources including esoteric Buddhist meditation11 and transpersonal psychology (Ōshita 2005: 245–248; Ōshita 2014: 204–212; see also Gripentrog 2018).

Here and there, Ōshita mentions the uniqueness of Japanese culture. When he refers to ‘animism,’ ‘pluralism,’ or ‘holistic thought,’ he sounds like an author of the so-called theories of Japaneseness (nihonjinron) genre, which promotes Japanese exceptionalism. He wrote, ‘The purpose of my workshop is for the participants to experience and acquire on physical level spirituality and view of death and life rooted in Japanese traditional culture’ (Ōshita 2014: 199). In sum, Ōshita emphasizes that the uniqueness of the Japanese spirit is rooted in its cultural traditions, which have been nurtured by Japanese religious culture, the most important being Buddhism. For example, he writes:

At the bottom of spiritual care and the life and death workshop, which makes use of temple settings, lies the idea of interrelatedness (engi; Sanskrit, pratītya-samutpāda, causality or interrelatedness) from Buddhist thought. [Interrelatedness is based on the concept of] en, which means the relationship between living beings along the time axis of past, present, and future. En is a significant word that has taken root deep in Japanese culture and customs since ancient times. (Ōshita 2014: 222)

Thus, Ōshita places Japanese cultural values at the core of his version of ‘spiritual care,’ utilizing Buddhist resources, including its vocabulary, rituals, and temples. However, if we are to distinguish ‘religious care’ from ‘spiritual care,’ his attempts could be more of an example of the former, because he does not hesitate to convey specific values with religious referents, at least implicitly. So the distinction between religion and spirituality does not matter much to him.

Wimara Inoue 井上ウィマラ

Wimara Inoue (b. 1959) used to be a Sōtō Zen monk, not born to a temple family, and then changed his denomination to Theravada. Wimala is an ordination name in Theravada, though he is now disrobed. I mention him here briefly because, from 2005 to 2019, he taught psychotherapy and spiritual care as a professor at Kōyasan University, the main university of the Kōyasan Shingon denomination. The founding of a spiritual care department at Kōyasan University in 2006 was quite an epoch-making project, since it was and has been the only university department with the title ‘spiritual care’ in Japan. After it was ultimately aborted in 2010, a two-year course for spiritual caregivers was opened from 2014 to 2019. It was Inoue who took charge of these projects at Kōyasan University (Inoue 2014).

Inoue explains his standpoint as follows: ‘I am trying to construct a spiritual care that integrates Vipassana meditation (Mindfulness), the most fundamental training technique in Buddhism, with psychotherapy, in terms of both technique and theory’ (Inoue 2014: 168–169). It was meeting with psychoanalysts in the United States and Canada, he writes, that helped him to cultivate his method, especially how to observe the breathing of others, a teaching that is absent from the original Vipassana sutras. While he refers to psychoanalysts like Winnicott
or Bowlby, he rarely mentions Japanese Buddhist practice, which shows that he seems to construct his system independently of the context of Japanese temple Buddhism. His concern in spiritual care is concentrated on how to communicate skills (or metaskills),\textsuperscript{12} which itself is not religious. As he repeatedly states in his writings, his goal is to apply meditation to the care of others. To Inoue, the essence of Buddhism lies not in a cultural guise connected with ancestor worship rooted in Japanese life, but in the skill of meditation. Thus, Inoue’s understanding of spiritual care is more psychological and therapeutic than that of other Buddhist theorists. It follows that he does not attend to the concept of ‘religious care.’

Yōzō Taniyama 谷山洋三

Yōzō Taniyama (b. 1972) is the youngest of the three, appointed as professor at Tohoku University in 2012, when the training course for interfaith chaplaincy (rinshōshūkyō-shi) was founded. As a Jōdo Shinshū priest (Ōtani denomination), born in a temple, he served several years as Buddhist chaplain in some hospitals, including Nagaoka Nishi Hospital, the first to host a Buddhist hospice. As one of the co-founders of PASCH (and the current chief supervisor), he has consistently been engaged in interfaith and ecumenical projects.

Taniyama distinguishes ‘spiritual care’ from ‘religious care’ in that, in the former, the caregiver brackets off his or her own worldview to enter the worldview of the care receiver. On the contrary, in the case of ‘religious care,’ the caregiver draws care receivers into his or her worldview and sometimes gives them religious advice (Taniyama 2014). It seems that Taniyama’s career as a hospital chaplain and his experience volunteering in disaster areas in 2011 made it necessary for him to distinguish between these two. In public spaces, ‘religious care’ should be provided carefully only when it is requested, since otherwise it would be taken as proselytism. He has consistently been interested in this theme, taking into account the political context of Japanese secular society. This is quite different from Ōshita and Inoue, who pay little attention to the limitation of religious care imposed by the secular settings.

Figure 12.1 Structure of spirituality (Taniyama 2009)
Taniyama’s Buddhist orientation is clearly seen in his ‘structure of spirituality’ (Figure 12.1), which is a revision of Kubotera’s. He placed eight factors clockwise that support one’s life. As one gets older, he explains, one thinks more of the eight factors important to one’s life in the order from one to eight. In so doing, Taniyama added a horizontal ‘realistic’ dimension as Ōshita did, adding ‘people’ and ‘things.’ But it is his addition of ‘ancestors’ (senzo) that is of vital importance in Taniyama’s revision (my emphasis in the figure). By this, he shows that ancestors are both transcendent and the most intimate beings to Japanese people, especially the elderly. They feel that a safe, peaceful life in this world is sustained by the existence of the ancestors, rather than the mighty God(s). Buddhist daily ritual toward family altars serves for the purpose of keeping good relations with ancestors. This is a central aspect of the spiritual life of the Japanese (Klass 1996). This insight into the relationship with ancestors has become a part of standard understanding of Japanese spiritual care. Following Taniyama (2009), Kubotera (2008) and Ōshita (2014) respectively added ‘ancestors’ to their own schemes of spirituality.

In some respects, Taniyama’s revision of Kubotera’s model could be regarded as a Buddhist modification of a Christian understanding of spirituality. First, the factor of ‘law’ or ‘truth’ apparently comes from Buddhist idea of ‘universal law’ (hō; Sanskrit, dharma), which complements the concept of a personified deity. Second, ‘ancestors’ is one of the central figures in the practice of Japanese folk Buddhism. Third, the interrelationship between the self and various factors from past to future is, as Ōshita (2014) mentioned, an expression of the idea of interrelatedness (engi or en).

**Popular, folk, and professional care**

Arthur Kleinman’s analysis of local healthcare systems as interactions between three sectors—the ‘popular sector,’ ‘folk sector,’ and ‘professional sector’ (Kleinman 1980: 49ff.)—sheds some light on each of these three Buddhists’ approaches to spiritual care. Ōshita’s approach fosters interaction between the folk sector (local temple settings) and the professional sector (clinical settings), while Inoue’s thought operates within the professional sector and does not extend to the folk sector. Taniyama, as his personal background and his leading position in the interfaith chaplaincy project indicate, is in favour of Ōshita’s approach in that each interfaith chaplain is a central actor in his temple (folk sector) and at the same time serves as a chaplain in hospitals (professional sector). Thus, the interfaith chaplain mediates between the folk sector and the professional sector. But Taniyama’s careful distinction of spiritual care from religious care and recommendation of refraining from the latter in public spaces, seems to weaken this mediating function of the interfaith chaplain. Taniyama, however, reveals his vision:

> My dream is that someday we won’t need the particular word ‘interfaith chaplain’ (rinshō shūkyō-shi) anymore. In other words, all the religious professionals will work as interfaith chaplains, providing kokoro no kea as a matter of course. I dream a society to be realised someday where all religious professionals will be tolerant of others’ faith and provide kokoro no kea every day.

(Taniyama 2016: 178)

Using Kleinman’s framework, Taniyama’s vision is that the folk and professional sectors will someday closely overlap when Buddhists act as care providers; or the boundary line, which divides two sectors, will disappear or become easier to cross. There seems to be a long way to go to reach that goal, as the number of Buddhist spiritual caregivers is still limited.
Interfaith chaplaincy certification

The Society for Interfaith Chaplaincy in Japan (SICJ, Nihon Rinshō Shūkyō-shi Kai) was founded in 2016 and the certification system for interfaith chaplains started in 2018. Today, SICJ is the largest body of spiritual caregivers with religious backgrounds, with over 270 members. Eight universities and one non-profit organization offer training programmes for SICJ. If a Buddhist priest plans to be certified as a rinshō shūkyō-shi, he or she is required to attend an official SICJ programme offered at the affiliated institutions. Though the programmes’ contents vary depending on the institutions, they require a minimum of ten hours of lectures on ethics and religion, ten hours of lectures on spiritual care and grief care, thirty hours of practical training in public spaces like hospitals, and twenty hours of supervision or group sessions.14 In the case of the two-year course offered at Tohoku University in 2019, lectures and group sessions are for 180 hours in the first year, and practical training, supervision, group sessions, and lectures are for 177 hours in the second year. After being certified as a rinshō shūkyō-shi, each chaplain is required to collect points by attending follow-up programmes to renew the certification in five years.

As of the end of 2019, SICJ had certified 186 chaplains, of whom about eighty-five per cent were Buddhist priests.15 My estimate is that they will continue to certify around thirty chaplains at most each year under the present training system.16 There are fewer than twenty supervisors, who have to train new trainees and supervise follow-up training programmes for the already certified, as well as doing their regular job as university professors or priests. While many of the certified are volunteer workers, far fewer are paid to be chaplains.17 Another similar training programme is offered by the Clinical Buddhism Institute (Rinshō Bukkyō Kenkyūjo), which certifies ‘clinical Buddhist chaplains’ (rinshō bukkō-shi). As its name suggests, this programme is more strongly Buddhist oriented than that of SICJ, and it does not use the term ‘spiritual care.’18 The number of certified rinshō bukkō-shi has been far less than the rinshō shūkyō-shi, so I will not go into detail regarding that programme.

Case study: a Buddhist spiritual caregiver in a palliative care setting

I would like here to refer to one example of a Buddhist interfaith chaplain serving in the palliative care setting. Taikō Kaneta, a young Sōtō Zen priest not much over 30, is employed at the palliative care ward of Tohoku University Hospital.19 Though he is only employed part-time, three days a week, this is the only case of a Japanese public hospital employing an interfaith chaplain for pay (as of 2020).20

Kaneta attended Tohoku University’s rinshō shūkyō-shi training programme in 2014. Soon after that, he started working once a week as a volunteer at Tohoku University Hospital’s palliative care ward. In 2016, he became employed part-time as an interfaith chaplain.21 This change of his status was important because, as an interfaith chaplain, he has access to inpatients’ medical electronic records, attends conferences with doctors and nurses, and is able to visit any inpatient at will, after an initial visit where he accompanied by a doctor or nurse.

Apparently, his daily routine is not different from that of hospital chaplains in the United States. He comes to the office at 10 a.m., reads inpatient records, visits patients to converse with them, attends a conference to share information with medical staff, reports verbally to nurses about inpatients, submits daily reports both electronically and hardcopy, and leaves the office at 5 p.m.
Buddhist spiritual caregivers in Japan

The following is a leaflet furnished in each patient’s room, explaining the role of an inter-faith chaplain:

Introducing Interfaith Chaplains: For Inpatients and Their Families

We have a rinshō shūkyō-shi (interfaith chaplain) available on this floor, who supports the kokoro (heart-mind) of patients and their families.

You may have your own way of thinking and feeling. But conversations with others can help you to regulate your feelings, gain a new way of thinking, or forget your sickness for some time. This could harmonize the relationship between your ‘body’ and your ‘kokoro,’ which is important.

The rinshō shūkyō-shi is there to listen to and think with each of you, to help lessen your burden. Please feel free to talk to him.

(1) Your health condition is our first consideration
The rinshō shūkyō-shi will not bother you when you are sleeping or disturb you if your condition is severe.

(2) The rinshō shūkyō-shi respects your thoughts and values
A Rinshō shūkyō-shi does not proselytise.

(3) The rinshō shūkyō-shi observes confidentiality
Whatever you tell the rinshō shūkyō-shi will be strictly kept secret.

(4) The rinshō shūkyō-shi is available
Monday, Wednesday, and Friday (11 a.m. to 4 p.m.)

These words are obviously written very carefully and politely for people who are unfamiliar with chaplaincy, mostly based on what is prescribed in the Ethical Code for rinshō shūkyō-shi.22 ‘Support of the kokoro’ (kokoro no sapōto) is a vague expression (which sounds like ‘kokoro no kea’), but it is much easier for patients to understand than ‘spiritual care’ (supirichuaru kea).

Kaneta just listens to patients. He looks like an ordinary young man in a white shirt and there is nothing visibly religious about him, though his shaven head makes it obvious that he is a Buddhist priest, which his title rinshō shūkyō-shi also indicates.

What is the advantage of his being a Buddhist priest? As Okabe’s words quoted earlier indicate, patients may be more ready to disclose their ‘spiritual needs’ to a Buddhist priest than to a layperson. One doctor testifies that patients look calm and peaceful after meeting with Kaneta, assuming patients tell him what they do not tell the doctors. But, he adds, an interfaith chaplain is necessary for the patients, not because he is a religious professional but because he is on the care team, the staff to increase the patients’ QOL (Kaneta 2016). This doctor seems not to fully acknowledge the advantage of his being a Buddhist priest, but there are some episodes that suggest the merit of this religious status.

A terminal patient confessed his guilty feeling toward his divorced wife and said that he wanted to apologize to her. He left a message before he died, ‘I realised at last that people live by supporting each other.’ Another terminally ill female patient said, ‘If I could live again, I would like to shave my head and travel around, to give thanks to everyone. I really hope to.’ In my view, these words deserve to be called ‘spiritual,’ in that they are concerned with the theme of sin and guilt, gratitude, the meaning of life, or hope for another life. These patients might not speak these words to doctors.
When I asked Kaneta if he consciously practised ‘spiritual care,’ he answered,

Yes, I do. I am conscious of my practicing ‘spiritual care.’ Though my approach to
the patients is in most cases in the style of active listening (keichō), I always keep in
mind that I should never fail to catch the words of the patients and their families with
my whole body and spirit. Or I am always consciously monitoring and examining
myself, in order to form mutually beneficial relationships (en). I feel this is also a
religious training (shugyō) for me as a result.

From these words, I assume, he is conscious of his own spiritual state and how it might benefit
the patients. The word en is, as mentioned earlier, a Buddhist term referring to karmic inter-
relatedness across time and space, not just the relationship between the caregiver and receiver.
Thus, ‘spiritual care’ is, to him, to assist patients in constructing spirit-to-spirit relationships.

Another question I asked to him was, ‘How Buddhist is your “spiritual care”? Or what do
you think is “Buddhist spiritual care”?‘ His answer was,

A middle-aged patient suddenly shed tears several days before she died, saying,
‘Suddenly I smelled incense [perhaps from Kaneta’s clothes]. It reminded me of
my peaceful childhood, when I would sit at the family altar (Butsudan), putting my
palms together.’ Then she put her palms together on the bed. . . . Another patient said
that, the instant I entered his room, he joyfully saw Kannon-sama (i.e. Avalokiteśvara
Bodhisattva). He might have thought I was Kannon, or he might have seen it behind
me. But it was not delirium or a hallucination. Our relationship continued until he
passed away. I remember I had these kinds of meetings from time to time. That is
meeting with the spirituality of people who have cultivated intimate relationships
with Buddhist culture. Therefore ‘Buddhist spiritual care,’ if there is any, might
be something that takes place in the interrelationship [between caregiver and care
recipient].

For Kaneta, it seems that ‘Buddhist spiritual care’ consists in supporting the religious senti-
ments the patients cherish in Buddhist culture. He added that training in spiritual care, espe-
cially the training of examining oneself, overlaps with the teachings of Yogācāra Buddhism,
and that they both aim in the same essential direction.

Though I did not ask him about it, Kaneta must have experienced hardships, frustra-
tions, and conflicts in his career. Japanese hospice chaplains providing spiritual care in
secular environments necessarily meet prejudice, misunderstandings, or over-expectations
from medical professionals, patients, and other religious professionals (Benedict 2018).
However, Kaneta seems to have been able to work largely in a favourable atmosphere.
This is partly because, apart from his own nature, the care team carefully prepared, as
in the aforementioned leaflet. Another reason is that priests and temples, or Buddhism at
large, create familiar impressions to people, especially the elderly, in the Tohoku district,
where most people are affiliated with the Sōtōshū denomination. Perhaps most importantly,
however, Kaneta can dispense with the tension between ‘spiritual,’ ‘religion,’ and ‘secular,’
because ‘spiritual care’ is, for him, not what he intentionally provides but something that
takes place spontaneously, depending on the patient’s familiarity or intimate feeling toward
Buddhist culture.
Conclusion

In this chapter, I gave an account of how Japanese Buddhist priests have struggled to adapt spiritual care to the Japanese social context. The common background is that Japan has been facing problems of care for the dying and bereaved in its ‘hyper-aged’ society. As the notion of spiritual care was brought to Japan in the late 1990s, medical professionals and religious scholars gradually realized its importance in the clinical field. The distinction between ‘spiritual care’ and ‘religious care’ has become a common strategy to apply spiritual care in a secular framework. This has enabled some medical professionals to exclude religion from the clinical field, because they regarded spiritual care as something that can be provided by secular professionals. On the other hand, for religious professionals, this distinction was the key to open the door to public spaces.

I emphasized Buddhist priests’ consciousness of their temples being on the verge of extinction in the face of criticism of funeral Buddhism. This is not only a financial problem, but also the problem of the identity or self-realization of Buddhist priests. Revitalizing temples through social engagement has been a pending project for Japanese Buddhists. The Vihara movement could be situated in that context. Then, the Great Earthquake of 2011 and the accompanying popularization of the term ‘kokoro no kea’ hugely impacted Buddhist priests, encouraging them to reconsider their identity as religious professionals. The idea of interfaith chaplaincy appeared before them as a new role as spiritual caregivers. As for the Buddhist spiritual care discourse, Taniyama’s introduction of ancestors was a great contribution in that it could lead to the re-evaluation and justification of folk religious practices related to funeral Buddhism.

Though I considered only one case of a Buddhist spiritual caregiver on the job, it provides a good picture of what they are doing with a different angle from previous studies on hospital chaplains in Japan. In Kaneta’s practice, we could see happy encounters of ‘the spiritual,’ ‘religion,’ and ‘the secular.’ This example illustrates how Buddhist culture can help provide end-of-life care in a secular setting. However, since it deploys religion for the secular, instrumental purposes prescribed by medical professionals, some Buddhists might also object to this development. I do not mean to suggest that there is necessarily a promising future prospect ahead of Buddhist spiritual caregivers in Japan. It can safely be said, however, that we are witnessing a new culture emerging, where caring is valued, be it spiritual or physical, and Buddhists are working to be major actors in this culture of care in order to secure their survival.

Notes

1 In this chapter, Japanese names are written with family name last.
2 All translations are my own.
3 This is based on personal experience and my conversations with the other founders of Tohoku University’s training programmes. Michael Berman portrays this challenge as ‘religion overcoming religions’ (Berman 2018).
4 Buddhist-affiliated universities that presently offer training programmes for rinshō shūkyō-shi (and their respective sect affiliations) include Ryūkoku (Jōdo Shinshū Hongan-ji-ha), Kōyasan (Kōyasan Shingonshū), Shuchiin (denominations of Shingonshū), Musashino (Jōdo Shinshū Hongan-ji-ha), Aichi Gakuin (Sōtōshū), Taisho (Tendaishū, Shingonshū Chisan-ha, Shingonshū Buzan-ha, Jōdoshū), Jōchi (Sophia) University (Catholic Jesuit) also has a programme. See Takahashi (2020).
5 All of these informants are men, but this is not because there are few women spiritual caregivers in Japan. Rather, 84 per cent of spiritual care providers certified by Nihon Supirichuaru Kea Gakkai (Japan Society for Spiritual Care) in 2017 were women. However, Buddhist spiritual caregivers
include far fewer women, especially among the supervisors. For example, in 2020, only 22 per cent of rinshō shūkyō-shi, including non-Buddhists, were women, that is forty-four out of 200. The question of gender in Buddhist spiritual care in Japan is yet another important theme to develop.

6 The number of its members is over 220 in 2020 (www.jabnvs.jp [accessed 10 January 2020]).

7 See also Sakurai and Kawamata (2016).

8 Following this, the definition of palliative care was revised by the WHO in 2002, with the word ‘spiritual’ added. See Kasai (2016).

9 Ando and Yuasa (2007) is an example of the collaboration of religious study scholars and transpersonal psychologists. See also Yuasa (2003).


11 Ōshita simply refers to mikkyō (esoteric Buddhism), not specifying denominations like Shingon or Tendai. In mikkyō meditation, visualisation training is important.

12 Metaskill here is something that sustains or contains the skill of care and cannot be conveyed to the learner verbally.

13 This is somewhat surprising, as Taniyama belongs to Jodo Shinshū, a denomination that pays less attention to ancestor worship, at least on the level of doctrine.


15 Of 146 chaplains certified at the start in March 2018, there are 121 Buddhists, four Shintos, eight Christians, and ten others (Takahashi 2018: 2).

16 Not all the trainees who receive the training programme become Rinshō Shūkyō-shi because the programme includes laypeople who become spiritual caregivers rather than chaplains.

17 Fifteen chaplains are paid for their work, including three who are employed full-time as of 2019.


19 The palliative care ward has twenty-two beds. The average length of stay of inpatients is about two weeks. (www.cancercenter.hosp.tohoku.ac.jp/kanwa/kanwa3.html [accessed 10 January 2020]).

20 The following description is based on Kaneta (2016) and a personal interview.

21 This was a brave decision by the hospital, as the doctors chose to employ an interfaith chaplain instead of a clinical psychologist from a limited budget.


Bibliography


