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PASTORAL VISITATION OF THE SICK: REFLECTIONS OF A JAPANESE PASTOR

by

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THESIS

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Abstract

This project was designed to show the importance of the pastor's role and actions in visiting the sick. The study is focused mainly on pastoral visitation to hospitalized patients. Interpreting the written texts of pastoral theologians and the research reports on pastoral care and practice in professional journals, I consider the pastor's important role as the representative of God and the symbolic nature of the pastor's role. On this basis, I discuss the pastor's actions in visiting the hospitalized patients. Prayer, a ministry of presence, and listening are the significant pastoral actions to the patients. In considering the patients' satisfaction with the pastor's actions, I found that the pastor's spiritual sensitivity was very important for most of the patients. I consider significant pastoral actions in the role of spiritual caregiver.

Based on these considerations, I refer to pastoral care and practice in Japan where I live and work. Despite facing particular difficulties there in pastoral visitation of the sick, I develop my vision of pastoral care and practice. Understanding of spirituality and reflections on the unique family dynamics in Japan are crucial.

TABLE OF CONTENTS

Introduction

"Jesus replied: " 'Love the Lord your God with all your heart and with all your soul and with all your mind.' This is the first and greatest commandment. And the second is like it: 'Love your neighbor as yourself.' All the Law and the Prophets hang on these two commandments." (Matt. 22:37-40)

" 'When did we see you sick or in prison and go to visit you?' The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.' " (Matt. 25:39-40)

Such statements take on increasing importance to anyone taking Christianity seriously. They become imperatives to those who, like myself, have responded to the call to ministry. But what if there are institutional and cultural barriers to carrying out such commands? That is the problem I face, and my reason for writing this paper.

There are other kinds of visiting besides that of prisoners that are important to Christians. I feel a particular call to visit the sick and dying in hospitals. But I live and work in Japan, a non-Christian country, where most of the hospitals and other medical facilities are government controlled and lack the historic, compassionate approach common in Canada and the United States.

There are also several kinds of compassionate visitors to hospitalized patients. Committed lay members of a church often do an excellent job, but this study, not being able to cover everything, will focus on the ordained ministry and its particular opportunities and drawbacks. "Pastoral visitation" then, will refer to visits by pastors, not to a more general expression of caring concern by anyone. Furthermore, the sick that most concern me here are the very sick, the dying patients.

To shed light on the problem I face, namely, how to do pastoral visiting of the sick and dying in Japanese hospitals, I first investigate pastoral visitation generally, then more specifically the role and actions of the visiting pastor. Both of these chapters deal mostly with the situation in the west, where such thinking and practice have developed. Then I consider the situation in Japan, with its quite different history, thinking, and social organization. Finally, I attempt to formulate a way to minister Christian love and compassion to hospitalized Japanese patients despite formidable obstacles to it.

Inevitably, ways of thinking and acting develop within and under some particular social system, even though this may be very difficult to recognize or admit. That certain ways of thinking and acting seem natural and normal shows what a strong determinant culture really is. "No one is more culture bound than the person who thinks he or she is not," an aphorism goes. This study involves at least two pairs of at least somewhat conflicting cultures: western vs. eastern, and Christian vs. non-Christian. I hope each can learn from the other.

The purpose of this paper, then, is to provide a better understanding of the pastor's role in visiting the sick, to study the pastor's significant actions to the sick, and to gain perspectives on pastoral care and practice in Japan.

My research questions accordingly are quite practical: "What is the Japanese pastor's role in visiting the sick?" and "What are the Japanese pastor's significant actions with the sick?" Inevitably, however, some more theoretical topics will have to be considered, such as a basic concept of pastoral visitation of the sick and the meaning of "pastoral."

For my research procedure and design, I will use a hermeneutical approach to answer my research questions, finding and interpreting the written texts of pastoral

theologians and the research reports in professional journals. I will focus on a theological understanding of the pastor's role and actions when visiting the sick. Research shows both similarities and differences in pastors' and patients' perspectives, and I will discuss them.

Similarly, when I consider the above topics in a Japanese context, I had to find and interpret appropriate Japanese writings. In some cases, I will provide my own translations—applied hermeneutics, if you will—as I interpret authors' meanings. It is not my intention to compare studies and research in pastoral care and practice in North America with those in Japan, because in Japan we do not yet have such studies. But as we Japanese learn from North American pastoral care and practice, we will become more aware of the importance of a pastor's role and actions with the sick person, and we will figure out how we can develop such necessary pastoral care and practice in a different culture and society. I will present, from personal experience, situations that Japanese pastors meet and the reasons they have difficulties in pastoral care and practice, especially in health care settings. I will reflect on my own experience as a parish clergy. And I will present, because they are important to this study, Japanese people's ideas and thoughts on religion and tradition, which influence their sense of death and dying.

Let us turn now to the general topic of pastoral visitation.

I. Pastoral Visitation

A. A purpose of visitation of the sick

We begin our discussion with the fundamental question, "Why does a pastor visit the sick person?" Then, "What are the reasons for the pastor to visit the sick person?" One may find and describe Jesus' ministry to the sick people in the Bible to provide answers to this question. It is quite easy to find a good example of Jesus' ministry to the sick people in the Gospels. Jesus went out to the people and found out those who need healing, care, comfort and forgiveness. He did not only handle those people with his physical intervention, but with his spiritual intervention. Jesus listened to the people and opened up their mind, their hidden spiritual concerns and conflicted feelings— in some cases, those which were never touched or listened to by anyone before. He also sent out his twelve disciples to preach the kingdom of God and to heal the sick. In the Gospels, we realize that pastoral visitation of the sick is regarded as the core part of Jesus and his disciples' ministry. In the tradition of the church, we have been following Jesus and his good example of care for the sick. In this sense, it is entirely fair to say, "The first reason we visit the sick, then, is to follow the example of Christ— and the tradition of the church, which has continued to follow his example through the centuries" (Becker, 1985, p. 22). Our ministry to the sick is founded upon Jesus and his ministry, and is endorsed in the tradition of the church.

When Jesus sent the Twelve, he gave them power and authority to drive out all demons and to cure diseases (Luke 9:1). We should note that power and

authority to cure diseases came from Jesus as his disciples pursued their ministry to the sick. Jesus' command to his disciples, "Take nothing for the journey", is very symbolic when we think about power and authority given to them. They were asked to take nothing for the journey, but were given full power and authority for their ministry. In the same way, the pastor is asked to go out and search for those who need pastoral care. In pastoral visitation of the sick, we have an opportunity to encounter people who have potential needs and to be a witness of Jesus who sends us with power and authority. And both the sick and the pastoral visitor are invited to this opportunity of healing ministry. The opportunity for this ministry is unique, because we may have a chance for spiritual growth in our relationship, sharing our stories and experiences through the pastoral conversation. Pastoral visitation of the sick gives us this opportunity. This is another reason to visit the sick.

Some pastors may find a further reason to visit the sick, which is a more concrete and practical one based on a religious or a clinical approach. Reassurance is important for the sick person who is isolated, tired with fighting illness and having emotional problems such as fear, anxiety and anger. The pastor goes to the sick person's bedside and makes an attempt to reassure him or her in many ways: showing intimacy with physical touch; sustaining faith development by reading the Bible and praying together; relieving the sick person's mind. The pastor, however, should restrain his or her attempt to reassure the sick person immediately. An attempt to reassure the sick sometimes goes wrong, especially, when the pastor does not realize the sick person's vulnerability

and does not respond well to the expectation from the sick person's side. The sick person may expect just the pastor's presence and compassion, not any particular words to reassure him or her. The pastor's intention to reassure the sick may work negatively if the pastor neglects or underestimates such expectation, which is rarely verbalized or expressed to the pastor. This may happen because the pastor follows his or her agenda and fails to see what is happening to the sick person on his or her side. When the pastor pays full attention to the sick person's agenda, he or she does not have to care about his or her own agenda, and so the pastor will provide the better pastoral care to the sick. As the pastor understands this, he or she can make a good decision to care for the sick and use his or her pastoral visitation fully to reassure the sick.

The pastor usually knows and identifies the sick parishioners before initial visits to the hospital or their homes. We can draw a picture in our mind of the shepherd who cares for his sheep in the Old Testament. The sheep are vulnerable without the shepherd and need care and nurture to survive. The shepherd is crucial for the sheep and has a special role to sustain their life. As the shepherd identifies his sheep and provides the daily care for them, so the pastor cares for his or her parishioners in the same manner. When the pastor visits the sick parishioners, he or she is working with full consciousness of being the representative of a congregation or church. Whatever the pastor's purpose, a representative role that belongs to the ordained ministry has the exceptional meaning in pastoral visitation of the sick. As Oden emphasizes, "ordained ministry has a special representative role in visiting the sick, which involves not

just conversation, but teaching, praying, healing, and consoling in Christ's name on behalf of the whole community" (1983, p. 249). Every pastor is responsible for this special role and needs to know that any purpose or reason for pastoral visitation of the sick is integrated into this role. The pastor presents him/herself as a representative of the faith community to the sick and shows his or her compassion and positive regard for them. This is essential to pastoral visitation of the sick and clarifies the purpose of visitation of the sick that we should remember in each visit.

Let us now consider this subject from another point of view. What professional or personal benefit can the pastor expect from joining this healing ministry? In other words, how does the pastor utilize this opportunity of the ministry for his or her professional or personal growth? VandeCreek and Gibson (1997) report in their survey of "Hospitalized parishioner satisfaction with the pastoral care offered by parish clergy" that most of the participatory patients strongly agreed that the pastor who visited them seems to be a person of spiritual sensitivity. As the pastor works with the sick, he or she is listening to any kinds of concerns and feelings of the sick with his or her spiritual sensitivity. Listening is an art of pastoral care of the sick, and the pastor has to be a careful and sensitive listener when he or she visits the sick. The pastor sometimes tries to comfort the sick, listening to what he or she is saying. A focus on listening to the sick is not to follow the pastor's agenda, but the sick person's agenda whose needs are spiritual comfort and sensitivity from the pastoral conversation. Pastoral conversation is a special gift for both the pastor and the sick, because

both of them are invited to a chance for spiritual growth and of pastoral encounter with the God of love. The spiritual growth for both the pastor and the sick may occur as they share their spiritual journey with each other. In view of this idea, let us then consider the pastor's professional and personal growth.

In visiting the sick, the pastor experiences each individual as the "living human document"[1] and learns to understand who they are and to interpret what they are experiencing. As the pastor is listening to the story of the sick, he or she interprets it and searches for the meaning. Searching for the meaning itself is not the purpose of the pastoral visitation, but it contains the purpose. Without searching for the meaning, any purpose of the pastoral visitation is not able to accomplish its goal. We assume that ministry to the sick has expectations that meaningful encounter and interaction may happen to the pastor and the sick. Through one's ministry to the sick, the pastor encounters the person who is living with sickness. It is significant for the pastor to share the patient's life story and to experience and find the meaning emerging from it. And the meaning has its own value; it is distinctive and is not replaceable by any other person's. As the pastor is aware of this significance in visiting the sick, he or she will learn and develop an understanding of each individual patient's own dignity and integrity. It is useful to quote from Gerkin when we consider this. He says, "Each individual living human document has an integrity of his or her own that calls for understanding and interpretation, not categorization and stereotyping" (Gerkin, 1984, p. 38).

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[1] Just as written texts are able to be interpreted, human actions are also able to be interpreted. "The living human document" is a key idea of clinical training in ministry (Anton Boisen, *The Exploration of the Inner World*, 1936).

Gerkin's idea leads the pastor to enhance his or her sensitivity to each individual's uniqueness and to facilitate his or her flexibility to deal with each different person in one's own conditions and context. And this improves the pastor's professional awareness to take responsibilities for one's role of pastoral office, and the pastor's clinical sense to access one's spiritual need. On the personal level, the pastor who reflects on the meaningful life story and experience can activate his or her thought and perspective on a meaning-making process in his or her life.

Joining ministry to the sick, the pastor can take advantage of an opportunity for professional and personal growth, which is necessary for becoming a good shepherd. This is also to the advantage of the congregation for which the pastor works. Now we could propose an answer to the question that we posed at he beginning of this section. For the question initially posed, "Why does a pastor visit the sick?" we have, then, several answers: because we follow the example of Jesus, who did so; because it is in the tradition of the church; and because the patient and pastor and a congregation can benefit from such a visit. In the next section, we shall consider "the call to ministry" to explain about the authority by which the pastor is sent to the sick.

It is useful to comment on a basic concept of the role of the pastor in visiting the sick before moving to the next section.

Oden (1983) emphasizes that the ordained ministry has a special representative role in visiting the sick. He states, "Ordained ministry involves not just conversation, but teaching, praying, healing, and consoling in Christ's name

on behalf of the whole community" (p. 249). Young (1954) points out the symbolic nature of the pastor's role and its significant influence to the patient.

> The pastor's influence is not limited to his own personal appeal but is enhanced by a figurative power that is as old as religion itself. Patients place the pastor in all kinds of emotional roles. A wide variety of feelings and interpretations are called up in the initial contact with an individual. This reaction necessarily results from the symbolic nature of the pastor's role because it occurs, many times, before a good interpersonal relationship has been established. (pp. 61-62)

A special representative role in visiting the patient and the symbolic nature of the pastor's role to the patient, these are interesting in that they show the foundational and comprehensive role of pastoral visitation of the sick. The purpose of pastoral visitation to the sick is strongly related to the pastor's role. In other words, why a pastor visits the sick is substantially correlated with what the pastor does for the sick. Holst (1985) states:

> It is my contention that *all pastoral care has a basic, primary, definable, fundamental role*. By role is meant a basic task or purpose as determined by one's office, profession, or position. Role is a combination of external (imposed) and internal (self) expectations. (p. 46)

His idea helps us to clarify and better understand the pastoral role, because he clearly points out two inherent dimensions to the pastoral role: external (imposed) and internal (self) expectations. We may say that the pastoral role is the desired role as well as the given role.

B. The call to ministry

What is the authority to send the pastor to the sick? Cabot and Dicks posed this question in their classic, *The Art of Ministering to the Sick*: "By what authority, then, does the minister go to the sick room?" (1936, p. 3). We may say that what they asked more than a half century ago still challenges us as an inevitable question. How can we respond to this? Why does the pastor need any authority to visit the sick? One of the critical discussions regarding authority is seen in the context of specialization (Cabot & Dicks, 1936; Moyer, 1989). In the current highly specialized profession, what is expected of the pastor performing as a caregiver in the health care setting? Cabot and Dicks present three goals of the pastoral visit. One of them is "To counteract the evils of specialism" (Cabot & Dicks, 1936, p. 3). They suggest that the pastor must have a job distinguishable from that of other specialists such as the doctor, the nurse or the social worker. They expect the pastor to treat the patient as a whole. They say, "The outline of the patient's entire life is the minister's concern" (Ibid., p. 9). The pastor, a caregiver of the soul, can treat the patient as a person who is living with sickness. The pastor does not see the patient from the medical specialists' points of view, which is focused on the patient's sickness. Rather, the pastor's specialty is based on the way that God creates us as a whole and nurtures with care. In this sense, the pastor visits the sick and provides the pastoral care as the representative of God. This representative role depends on the authority and the authority comes with the Call. As Moyer states, " Pastoral care of the sick, in and out of the

hospital, must always be defined in terms of the authority of the Call" (Moyer, 1989, p. 176).

As we think about the authority of the Call, is it clear who can authorize the Call? Oden (1983) explains this problem in terms of "the inward call and the outward call" (pp. 18-21). Any call to ministry essentially comes from God and we respond this call inwardly and outwardly. The inward call is a personal and subjective response to the call to ministry and this must be examined to prepare for the outward call. The outward call is the external response to one's internal call and is examined in the official process, using some criteria. Someone who is convinced about the internal call to ministry needs the confirmation by the outward call and the outward call is the affirmation by the faith community. Oden (1983) remarks the following:

> The call to ministry requires not only a private, inward, intuitive feeling that one is called by God to ministry; if we had only that, we would invite the abuses of self-assertive, subjective, individualistic self-righteousness. To avoid these abuses, it also requires the affirmation of the visible, believing community (p. 20).

The inward call and the outward call work not only for one's ordination process, but also for one's entire process of ministry. As we consider the features of the call, it is obvious that the call permanently affects one's ministry. This does not mean that the call is rigid and that the pastor may not have a chance to reconsider his or her call and to hear the alternative voice of a call for challenging future ministry. The pastor needs to hear the voice of the call in every occasion

that he or she works for the faith community. The pastor can hear this voice of the call only by responding to the call, which is inwardly a gift to the pastor and is outwardly a blessing for both the pastor and the church. The authority of the call is not the pastor's belonging, but an endorsement with the power and the authority for pastoral ministry. When the pastor visits the sick, the pastor has nothing less than the endorsement of this authority. With this endorsement, the pastor has the right to go into the sick room and serve the sick.

C. Hospital visitation

It is very common for the local pastor to visit the sick parishioner in a hospital since hospitalization or institutional health care is generally accepted in contemporary society. There are a variety of reasons to be hospitalized. And the pastor has not a few chances to visit his or her parishioners in the hospital. It is relatively easy for the local pastor to visit the hospital and the sick if he or she is regarded as a spiritual caregiver and is allowed to see the patient without being much restricted by the hospital regulations. Some hospitals, which have active chaplains and pastoral care services, cooperate with the local pastor in pastoral care and provide a supportive environment. The pastor may experience less stress in his or her pastoral activities when he or she takes advantage of such cooperation and supportive environment. This is very important for the pastor to provide good quality of care to the sick. To take a simple example, some hospitals do not charge the local pastor for the use of the parking lot. This service is helpful for the pastor frequently visits his or her parishioners in the hospital. This shows that the hospital is willing to provide a supportive environment for the

pastoral hospital visitation. It is not just a financial support. It helps the pastor feel more accessibility to the parishioner-patient during the period of hospitalization. This includes not only the physical accessibility, but also the psychological one. Compared to the hospital chaplain, the local pastor's activity in the hospital is obviously limited, because parish clergy are not a part of the hospital treatment team, even if they are well accepted by the hospital staff. We assume that most parish clergy recognize this limitation and agree to accept it. In spite of this limitation, the pastor can provide good quality of pastoral care to his or her parishioners in the supportive environment which the hospital maintains.

The pastor needs to know about hospital environmental problems to provide a good quality of pastoral care for the hospitalized parishioners. Firstly, hospitalization is not one's desired choice, but a necessity. People want to avoid being hospitalized, if possible. The pastor needs to know how hospitalization affects one's life and causes drastic changes. Secondly, the pastor needs to know about institutional and environmental problems of hospitals. Hospitals have regulations, rules and limitations to maintain the institutional environment. These regulations and rules vary in each different hospital and in different societies in different countries. For example, not a few hospitals in Japan have inhumanly rigid rules as to visitors and visiting hours. There is no exceptional rule applied to significant others such as spouses, children and clergy.

The pastor needs to know these situations and to respond in each case appropriately. Hospitalized patients are placed under these circumstances and are away from the normal social life of most healthy people. In the survey of breast

cancer patients' satisfaction with clergy, Johnson and Spilka (1991) found "high correlations between satisfaction and the feeling of being understood by the clergy" (p. 24). And they pointed out that being understood is independent of the home minister's other activities related to the patient. The hospitalized patient experiences various kinds of unpleasant feelings; he or she has difficulties coping with drastic changes in his or her life and he or she needs the patience to associate with hospital staff and other inmates. All these feelings, changes and difficulties related to the patient should be included in the pastor's concern. The pastor is not almighty and is not able to handle all these concerns about the patient, but should keep them all in mind. The important thing is that the patient feels understood by the pastor.

Understanding the patient is difficult for the pastor if he or she does not perceive the different situation between the sick person and the healthy person. This difference is originally caused by illness, and is expanded by the hospitalization. Then, what does the pastor need to understand the patient? The pastor needs compassion to care for the patient who is weak and hospitalized. Compassion is the key for understanding the sick. It is the bridge encouraging the proper and necessary interaction.

Marcus Borg, a professor of Religion and Culture at Oregon State University, writes about compassion as follows:

> *Compassion* is a particularly important word in the gospels. The stories told about Jesus speak of him as having compassion and of his being moved with compassion. The word also represents the summation of his

> teaching about both God and ethics. For Jesus, compassion was the central quality of God and the central moral quality of a life centered in God. These two aspects of compassion are combined most clearly and compactly in a single verse, to which we will return several times in this chapter: Be compassionate as God is compassionate. (1994, p. 46)

In Chapter One, we discussed the purpose of pastoral visitation of the sick and pointed out the important role of the ordained ministry. We found the basis of pastoral visitation of the sick in Jesus' and his disciples' ministry to the sick. We learned that his disciples were given the authority and the power by Jesus to heal and comfort the sick.

A pastor pursues the ministry to the sick as he or she follows Jesus and his ministry to the sick. We found that the pastor has a special representative role in visiting the sick. This representative role is correlated to the symbolic nature of the pastor's role. This role comes from the authority of the call. The pastor responds to the call to ministry to the sick both inwardly and outwardly.

We pointed out several aspects of the pastor's role in hospital visitation. The pastor may experience some limitations and difficulties in visiting hospitalized patients. Those are mainly hospital environmental problems. The pastor needs to know hospital environmental problems that affect patients in order to provide better pastoral care. The pastor's compassion is crucial for the understanding of the hospitalized patients' conditions and situations.

Let us turn now from this general topic of pastoral visitation to the more particular and practical issues of the pastor's role and actions when visiting the sick.

II. The Pastor's Role and Actions in Visiting the Sick

A. Expectations from hospitalized patients

In the previous chapter, we discussed a basis of pastoral care of the sick. In this chapter, we shall begin by considering hospitalized patients' reflections and evaluations of a pastor's activities in a hospital visitation. There is not much research published regarding parish clergy's pastoral hospital visitation. For this reason, it is fortunate that Sarah C. Johnson & Bernard Spilka and John D. Spangler & Constance B. Nelson have carried out comprehensive and detailed research about parish clergy's hospital visitation and pastoral actions considered from the hospitalized patients' point of view.

Johnson & Spilka (1991) examined breast cancer patients' evaluations of and reflections upon a pastoral visit done by both home pastors and hospital chaplains. The researchers considered the meaning of a pastoral visit and what pastoral actions pleased the patients. One hundred and three volunteer women through American Cancer Society (ACS) participated in the program and were interviewed. According to their data, 23 women (22.3% of 103 women) were visited in home and 58 (52.4%) were visited in hospital by their home pastors. Eight women (9.5%) in home and 38 (39.3%) in hospital were visited by hospital chaplains. The results showed that most of the women visited were pleased with the home and hospital visits by their home pastors and chaplains. Some 92.7% of the women visited in home were pleased with their home pastor's visits and 96.2% of them were pleased with their home pastor's hospital visits. They also highly appreciated hospital chaplain's visits: 98% to a home visit and 97.1% to a

hospital visit. These high marks demonstrate the fact that clergy receive a fairly favourable response to their pastoral visits from the patients.

Next, we shall present major research outcomes regarding actions of clergy during visits. The patients were asked which actions their home pastor took, and several aspects of prayer topped the list: some 58.6% of the patients said that their pastors offered to pray for them, 50% that he/she offered to pray with them, and 53.4% that the pastor actually did pray with them. Fairly close, at 53.4%, was the number of the patients who felt the pastor "Understood feelings, concerns." This was followed by "Talked about patients' family"(43.1%).

From this result, we may say that the most common pastoral action to the sick is prayer. There is, however, one point that we must draw attention to—namely, that it is not fair to evaluate prayer's significance apart from the other pastoral actions of "understood feelings, concerns" and "talked about family." Prayer is meaningful when the other pastoral actions provided are involved in the pastor's prayer. It is important that the patient's feelings and personal concerns including family affairs are carefully listened to and understood by a pastor when a pastor offers prayer and prays with a patient. It is also important for patients to be ensured enough time and a relaxed atmosphere to speak about their feelings, concerns and family. To put the assertion more concretely, a pastor's prayer reflects on what a patient and a pastor talked about in their conversation and reinforces or ensures a patient's perception that he or she is understood.

Prayer, to put it the other way round, tends to be meaningless when a patient does not feel good about a pastoral conversation—that he or she has not

been understood and his or her feelings and concerns have not been carefully listened to. As we focus on the religious aspect of prayer, prayer is genuinely a religious action and is basically dedicated to God or the sacred. As we focus on its clinical application and meaning of prayer, what Johnson & Spilka pointed out is quite suggestive:

> The "power of prayer" is not to be taken lightly. It represents a form of control that identifies the individual with ultimate power sources. Prayer has also been treated as an active cognitive coping strategy that relates positively both to problem-focused and successful emotion-focused coping. (1991, p. 29)

We should note one point—that pastors should not rely on prayer alone, important as it is. A pastor's prayer, as we mentioned above, works most effectively in combination with other significant pastoral actions. If a pastor depends only on uninformed prayer, a pastor's prayer may fail to grasp a patient's mind.

VandeCreek & Cooke (1996) studied the hospital pastoral practices of 471 Christian parish clergy or official lay representatives who visited parishioners at a university medical centre. VandeCreek states: "The most common pastoral practices were praying with parishioners and assuring them that others were praying for them" (1998, p. 198). The findings of this research correspond with what Johnson & Spilka found about clergy's hospital activities.

Parish clergy and lay representatives try to comfort and reassure patient-parishioners with prayer. It is important for hospitalized parishioners, who are

away from regular church attendance, to know that others remember and pray for them. This reminds them of friendship with each other in the congregation and of membership with the church. Friendship and membership are important factors to ensure that patient-parishioners continue to feel affiliated to their specific faith communities. Although they are physically away from regular church attendance, they can share their thoughts and minds with pastoral or other compassionate visitors. Prayer has the power to attach one's thought and mind to other people even if one is physically away from them.

We shall briefly summarize the above discussion. Prayer is the most common pastoral action of parish clergy who visit hospitalized parishioners. This was found by both studies: one focused on patients' evaluation and the other on parish clergy's evaluation. Prayer functions with other pastoral actions and its integration with these pastoral actions is necessary. Although we can observe that prayer has an effect on spiritual and physical healing, we should not expect prayer by itself to be of much importance if exclusive of other pastoral actions. Rather, it is fair to say that prayer produces a direct or indirect effect on one's healing process when a pastor maintains a good relationship with a patient, creating trust with each other.

Let us, for the moment, consider other examples. VandeCreek & Gibson (1997) studied parish clergy's hospital visits and examined hospitalized parishioners' satisfaction with the pastoral care offered by parish clergy. They chose 500 hospital patients from the daily admitting lists at a university-based medical centre in the Midwest section of the United States and interviewed them.

The interviewer used a 21-item questionnaire which was an adaptation of the Patient Satisfaction Instrument for Pastoral Care (PSI)[1] and the patients responded to each item on a four-point scale (1=strongly disagree; 4=strongly agree) regarding the pastoral visits. Eighteen of the 21 items were psychologically positive statements, and each of their mean scores was well above 3 ("mildly agree"). The highest mean score was 3.88: "His/her prayer(s) is a comfort to me" and the lowest one was 3.06: "He/she helps me cooperate with the doctors and nurses." The second and third highest scores concern the pastor's spiritual sensitivity ("He/she seems to be a person of spiritual sensitivity", and "His/her visits help me to realize God cares for me"). The findings of this research suggest that pastor's prayer and spiritual sensitivity are the most important pastoral actions for hospitalized patients. (Table 1)

As we consider the reason why prayer is the most common and appreciated pastoral action, we may say that it mostly depends on a pastor's identity as a religious person. A pastor's role and vocation to minister to God's people are closely related to his or her practice of prayer. In other words, prayer leads a pastor into specific pastoral ministry, and every pastoral activity needs his or her confidence in prayer. A patient's expectation and satisfaction also motivate a pastor to pray for and with a patient at every occasion.

It is important to note that a pastor's spiritual sensitivity as well as his or her prayer is desired by many patients. A pastor should have spiritual sensitivity in order to have a better idea of what and how to pray in each unique occasion.

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[1] VandeCreek, L., and Lyon, M. (1992). Preliminary results from a patient satisfaction instrument for pastoral care. *The Caregiver Journal* (Vol. 9), No. 1, pp. 42-49.

Table 1

Hospitalized Parishioner Satisfaction with the Pastoral Care Offered by Parish Clergy

Positive items	% Resp.	Mean	S.D.
1. His/her prayer(s) is a comfort to me.	99	3.88	.47
2. He/she seems to be a person of spiritual sensitivity.	99	3.85	.48
3. His/her visits help me to realize God cares for me.	97	3.83	.49
4. He/she helps me use my faith/beliefs /values to cope with my feelings.	94	3.77	.59
5. He/she fills my need for the sacraments.	76	3.76	.60
6. He/she gives me the impression of really listening to me.	95	3.76	.61
7. He/she seems to know what they are doing during our visit(s).	93	3.71	.64
8. After talking with him/her I feel better about my problems.	94	3.68	.60
9. His/her visits help me feel more hopeful.	94	3.66	.64
10. His/her visits help me face difficult issues connected with this situation.	89	3.62	.67
11. His/her visit(s) make my hospitalization easier.	97	3.61	.68
12. His/her visit(s) aid my spiritual growth through this experience.	95	3.61	.72
13. His/her visits give me strength to go on.	93	3.61	.71
14. His/her visits help me over my fears.	85	3.56	.72
15. He/she helps me adjust to my medical situation.	89	3.51	.69
16. His/her visits contribute to a readiness to return home.	86	3.50	.78
17. His/her visits contribute to a faster recovery.	92	3.45	.81
18. He/she helps me cooperate with the doctors and nurses.	62	3.06	1.04
Negative items			
1. His/her visits scare me.	89	1.22	.69
2. He/she talks too much during the visit(s).	89	1.27	.66
3. His/her visits make me too tired.	92	1.46	.85

Source: VandeCreek and Gibson (1997) table 2

A pastor, with his or her sophisticated sense of religion and spiritual sensitivity, is expected in his or her prayer to respond to a patient's expectation and wishes appropriately. It is quite important, as we mentioned in the preceding chapter, that a patient has a sense of being understood by the pastor. Johnson & Spilka remark: "Being understood, however, is independent of all of the other activities by which the home minister relates to the patient" (1991, p. 24). A patient expects pastors to have spiritual sensitivity so that he or she can express and share his or her concerns with them. A compassionate pastoral visitor relies on his or her spiritual sensitivity to understand and not discourage a patient who is suffering from pain, isolation, fear and impatience, rather than on his or her knowledge. The patient's realization of being understood depends on a sense of acceptance by the pastor.

The third pastoral action we consider, following pastor's prayer and spiritual sensitivity is, as we have seen, to remind patients that God cares for them (VandeCreek & Gibson, 1997). It is safe to say that a pastor's representative role of God affects this pastoral action positively. For this reason, pastor's visits can help the patients to realize that God cares for them. "The symbolic nature of the pastor's role" (Young, 1954, p. 61) is embodied most in a pastor's representative role of God. Therefore, we should say that a pastor's role in visitation of the sick carries a great responsibility with it.

My own clinical experience as a hospital chaplain confirmed that there are few patients who have no difficulties with their hospitalization. They experience pain, anxiety, fear, sorrow, isolation and anger because of their hospitalization. A

pastor's visit will help patients cope with such difficulties if it affects them positively. In fact, a number of respondents recognize that a pastor's visits make his/her hospitalization easier and also help him or her face difficult issues connected with this situation (VandeCreek & Gibson, 1997).

As we consider the difficulties that hospitalized patients may experience, we firstly recognize a variety of unpleasant physical and mental conditions they have to cope with. Such conditions are mainly caused by illness itself. In addition to that, we observe another serious problem connected with hospitalization—it constitutes a minor or major change in one's life. One's daily life or routine is inevitably transferred to different conditions in restricted places or environments. When accompanied by such changes, any financial, social, and family problems that the patient meets must necessarily be even more stressful.

A hospital has its environmental problems peculiar to institutional settings. Once patients are hospitalized, they need to respect and obey the general rules and regulations fixed in each hospital. They also need to cooperate with hospital staff. In particular, they will have many chances to see medical staff such as doctors and nurses during their hospitalization. Social workers, physical therapists and occupational therapists may also be involved if necessary. A patient will see a hospital chaplain if pastoral care service is available. It is important that the hospital staff be a helpful resource for patients during hospitalization in order for them to adjust to the different environment and to make their hospitalization easier. By contrast, all other people from outside are visitors. They are under limitations as to visiting hours and opportunities to see

patients. Both patients and visitors may be frustrated at such limitations. Home pastors are not exempt from such limitations. Unless they are hospital staff, they may have to visit their parishioners under the rules and the regulations for all visitors.

Although subject to such limitations, visitors from outside have unique and important roles for care of the sick. They can carry and provide "fresh air" and a moderate stimulus to patients from the outer world. On the other hand, hospital staff spends most of the time with patients and colleagues in the institutional settings apart from the outer world. Hospitalized patients need visitors who carry and provide information and ideas connected to the patients' personal concerns in the outer world.

Because hospitalized patients are separated from the outside world, it seems reasonable to suppose that visitors carry to the sick room a portion of the patient's ordinary life and offer familiar faces. Especially, a pastor, carrying a religious stimulus to the sick room, sustains and enhances a patient's faith and spiritual life. For example, a pastor's visits can comfort a patient's loneliness due to absence from their church, and can fill their religious and spiritual needs with his or her presence and religious activities. Furthermore, a pastor's visits help patients realize that God cares for them.

It follows from what has been said that a pastor helps a patient's inner life, feeding values and qualities of life that comprise the patient's spirituality. Patients realize that their quality of life is maintained and nurtured by the presence and actions of a compassionate pastoral visitor, even though they remain

in the different situation of hospitalization. A pastor will actively pursue this role, praying for God's intercession.

B. Pastor's actions in the role of spiritual caregiver

As we mentioned in the previous section, some hospitalized patients showed their satisfaction with and expectations of the pastor's spiritual sensitivity. It is not easy to define spirituality because each person has a different idea and thought about spirituality. We should not use our own judgment for the others. Even if we have dissimilar values from others we also share many in common. That does not mean that our ideas of spirituality are not the same as others. Although we have similar values in some aspects of life, we also have many differences. It is very natural because it is rewarding to hear the harmony of different tunes rather than a single tune. Each person has a different value and idea about spirituality which is not the same as others'. We may liken this to having a musical instrument which sounds differently according to each player. It is important to say that how we respond to each person's sound reflects a pastor's spiritual sensitivity. It is easy to respond to the sound which someone makes if we are sensitive to that sound. In contrast, it is difficult to detect a sound if we are insensitive to that sound. We have something to say even when we do not know what to say about our feelings. We hesitate to disclose family conflicts to others and hide our feelings. We may become psychologically defensive unless we are relieved from such feelings. We need sophisticated spiritual sensitivity based on a caregiver's compassion and positive listening.

We also need concentration and energy in order to listen to the signal which someone expresses. We may need a long time to respond well to the signal or message that someone is sending. But also, we are sometimes asked for an immediate response to understand situations and provide appropriate help to others. When we consider the pastor's role in ministering to the sick the pastor has a role to assist a sick person's spiritual need using the pastor's spiritual resources. It is also important for medical staff, hospice friends and volunteers to use their own spiritual resources in caring for the sick. When someone gets sick and is hospitalized he or she has a spiritual pain. Along with losing physical health someone may experience a challenge to their self-esteem.

The sick person has spiritual pain when he or she has to accept living with illness. They may have questions about being sick. For example, "Why do I have to have cancer?" or "Why does God allow me to suffer from this illness?" These are fundamental questions and so it is normal to experience spiritual pain. But also, it is a chance to grow spiritually when someone experiences spiritual pain because they have important questions about the meaning of pain. The question "Why?" varies in each person because the meaning which is deeply related to one's life is unique. As Viktor Frankl says, exploring the meaning is important. We ask "why" when we face difficulties. It's the beginning of exploring the meaning when we ask ourselves "why this should happen to me." There is a meaning to any question when we experience spiritual pain.

A pastor as a spiritual caregiver needs to accumulate a lot of reflective experience in order to improve his or her own spiritual sensitivity even if a pastor

does not have any experience of being hospitalized. He or she has a positive role to understand the sick person's spiritual pain and to join the patient who is exploring the meaning. When a pastor discourages hospitalized patients and their family members, it creates dissatisfaction.

According to Johnson and Spilka, some items of dissatisfaction are prayer and clergy visits. For example, "One woman wanted her minister to pray for a miracle, but he refused." Another patient said, "A pastor told a patient that she was a sinner and unsaved." We assume in the first example that an unknowing minister refused a patient's request to pray for a miracle because the pastor may doubt a miracle because of his or her own theological stance. That minister lacks inside sensitivity to the patient who is struggling to be cured and thinks only of holding his own theological stance. That minister may be concerned about his or her own comfort, and his or her attitudes caused the parishioner's discomfort. We infer from the second example that the pastor comes from a denomination with some dogmatic background. We noticed in these examples that the ministers misused their theology even if it is reasonable for them.

Any pastoral ministry is based on theology. We, however, should not judge people in our theological framework. It is fair to say that we pursue theological work to relieve the sufferer from any kind of pain and to understand them. We would never say to the patient afflicted with breast cancer "You are a sinner and unsaved" if we have a right understanding of salvation and reconciliation, which are major issues in Christian dogma. God's salvation and reconciliation are messages of forgiveness of our sins and God's promise. If a

pastor closes the gate to God's salvation and reconciliation his or her theological work discloses that he or she has a critical failure.

Here is a third example. A parishioner, who was an active church member was never visited by her minister during her hospitalization, reluctantly confessed feeling abandoned, "I felt abandoned by my church - but not necessarily by God.... I cannot bring myself to return." Johnson and Spilka commented on this example, "In this day of pastoral sophistication, it is hard to believe that such insensibility still exists" (p.30). Here is a good chance to talk about the role and the meaning of pastoral theology. We need practical ideas to use in pastoral practice. We confuse those who are objects of ministry when we do practice without any practical application, as in the above example.

The role of pastoral theology is to provide a basic framework for pastoral ministry and to give a chance to evaluate the meaning and to help pastoral practice and reflection. It is a pastor's role to assess patients' needs and to respond to them appropriately. It comes from Jesus' teaching: "In everything, do to others what you would have them do to you, for this sums up the Law and the Prophets" (Matt. 7:12). It is not easy to understand clearly what a patient needs. In particular, it requires a pastor to develop insight into his or her own spirituality, because a pastor's attitude, ability, and availability strongly affect the assessment of the patient's spiritual needs. A pastor needs to reflect on whether his or her attitude is defensive, whether consciously or unconsciously. If a pastor works with patients without insight into the reason why he or she takes some certain actions, the pastor's actions may cause a negative reaction in the patients. A

pastor needs to be aware of his or her psychological reaction, as when he or she has pain, fear, and anxiety in dealing with a patient. It is very difficult for a pastor to understand a patient's inner experience if the pastor is not aware of such personal psychological reactions. A pastor also needs to prepare him/herself to deal with patients and to share their pain, fear and anxiety. As the pastor develops a good relationship with a patient, it is quite natural that the patient wants the pastor to understand their expectations and wishes. Preparation beforehand is necessary for the pastor if he or she is to respond well. There are two sides to the pastoral role, "internal and external" (Holst, 1985, p. 46). A pastor wants to be able to respond spontaneously to whatever arises, but at the same time needs to be aware of what others expect.

As we have mentioned before, a pastor is not an all around player. There is no caregiver who can respond to every kind of expectation and need. Rather, it is necessary for a pastor to recognize his or her limitations, these are his or her growing edges, not weaknesses. Some pastors experience strong fatigue when a patient and/or family members face a particularly difficult problem. It may be quite a challenge to handle a problem which is not easily resolved. In that case, a pastor may be confused and tested. However, we may say that it is a chance to gain fresh insight and vision through such experiences. Spirituality does not keep one's heart in condition—that is, when one's spirituality is healthy one can see the world positively, but when one's spirituality is weakened, the world may seem different. So, in other words, spirituality has dynamism to it. Our spirituality echoes the other's spirituality as we touch it. It is crucial for a pastor to respond

appropriately to a patient with words and actions that are easily understood. That suggests a communication problem.

In the next section, we discuss this communication problem as we focus on pastoral conversation and spiritual growth.

C. Pastoral conversation and spiritual growth

Curiously enough, an important insight into illness is given by the Japanese way of writing.

Illness is called *Byōki* in Japanese and is written "病気" in *kanji* or Japanese characters. The second character *Ki* (気) means human mind or spirit. It is an expression peculiar to Japanese and has no equivalent expression in English. There are many expressions using *ki* in Japanese and they are very useful for expressing and explaining one's feelings and mental conditions. The first character *Byō* or *yamai* (病) means illness and has a verbal expression in this usage: *byōki*. The word *byōki* therefore implies that illness correlates with some mental condition. The word *byōki* is used not only to express one's physically ill condition but also to express one's mental or spiritual weakness which accompanies one's physical weakness. We understand that our illness may be caused by stress or fatigue in some difficult condition. Conversely, it is common that we experience stress, fatigue and unstable mental conditions even if we have minor symptoms such as fever, headache and stomach ache. Therefore, we may say that our illness correlates with a mental condition. The Japanese word *byōki*, thus, recognizes the inherent interconnectedness of physical and mental conditions.

It is very hard to say that we can prevent illness because we humans are living organisms. As long as we live, we cannot avoid getting ill. As we mentioned, our physical and mental conditions are affected by illness. It is tough for us to experience weakness caused by illness, even if it is for the short term.

We may have to change our schedule and future plans because of illness or hospitalization, and such experience may remind us of our vulnerability and mortality. We hope to avoid such uncomfortable experiences if possible. We, however, may not say that such experiences are not worthy of consideration, because we may derive a meaning from our weakness accompanied with illness.

When we are sick and weak, we realize how we depend on those we receive care from. We learn to appreciate them from our experience of illness. At the same time, we have a chance to reconsider our vitality toward recovery and to reflect on a positive aspect of life.

A pastoral visitor understands that the sick person has his or her own dignity and autonomy to respect. In other words, a pastoral visitor has an opportunity to see each individual as a spiritual being. One's spirituality must be respected because it belongs to one's dignity and freedom. When we get sick, we have a pain in our spirit and feel fatigue and weakness. Such experience need not end up as a negative experience, because our spirituality might be able to experience and grow through illness.

It is certainly true that our spirituality is affected by an uncomfortable physical condition and the unsettled emotional condition accompanying it. It is also true that weakness caused by such physical and emotional conditions may

change to become the growing edge for the one who perceives his or her experience as an opportunity of growing. We should not apply this idea to every patient in our pastoral visits. We believe, however, that this may happen to anyone. It is necessary for the pastor to focus on a patient's need at the moment rather than the pastor's agenda. But a pastor should not pry into a patient's inner world just for curiosity.

Becker (1985) suggests "presence and understanding" as two most significant ways of pastoral care of the sick and says, "These two are really two sides of the same coin: compassion" (p. 32). The ministry of presence was a basis of the pastoral role, and "the symbolic nature of the pastor's role" (Young, p. 61) was fully demonstrated in this presence as we have mentioned before. The pastoral presence has a meaningful effect on a patient.

"Understanding" is crucial to building a good relationship between a patient and a pastor. It is a key for a good relationship. A patient needs to be understood by a pastor. This has been pointed out as we discussed Johnson & Spilka's research in section A in this chapter. The ministry of presence, as Becker points out, does not mean that a pastor does nothing. A patient responds well to a pastor and appreciates a pastor's visit when a pastor gives full attention. Through his or her presence, a compassionate pastor has the power to create a meaningful interaction with patients.

Then, what does a pastor do for the sick when he or she visits the sick room? A pastor represents the church and/or God. A pastor also attempts to understand the sick, invites a patient into pastoral conversation, and facilitates the

sharing of his or her personal concerns or spiritual journey. To carry out this pastoral role, a pastor needs to be a good listener, listening carefully to the facts and meaning that a patient presents. It is no exaggeration to say that the role of a pastor in visiting the sick is condensed into this pastoral role: listening. A pastor as a good listener should have spiritual sensitivity that will focus positively on the patient's concerns. Listening is an art, and a good listener has sophisticated skill and accumulated experience, both developed by clinical pastoral education.

In Canada, there is a training program available for active parish ministers as well as seminary students: Supervised Pastoral Education (Clinical Pastoral Education and Pastoral Counselling Education). They have a chance to have supervision of their ministry and their theological reflections. In Japan, it is exceedingly rare to have a certified clinical supervisor. Therefore, parish ministers cannot take advantage of the practical feedback from a supervisor to improve his or her listening skill for clinical practice. Listening is an art and a skill. It has a certain style, form and pattern. A pastor needs to understand them as he or she reflects on his or her pastoral conversation.

Let us now attempt to extend the observation into a pastor's action as a listener. What does a pastor expect from the pastoral conversation with a patient? In other words, what kind of topics do a pastor and a patient bring up and share with each other beyond a friendly talk? As a pastor initiates a pastoral visit and develops a good relationship with a patient, he or she will gradually learn about the patient's beliefs, faith and values. In the process, a patient may gain a more profound insight into self and the world. A patient eventually gets a fresh insight

into life. We may say that this process is a spiritual journey, and to gain a fresh insight into life is spiritual growth.

> Cabot and Dicks (1936) describe spiritual life as follows:
>
> Spiritual life means the growth of each soul along the plan of its individual nature. That plan steers us toward depth and away from superficiality in knowledge, away from shallow emotion and from vapid struggles with ourselves. (p. 18)

The insight of this passage is that we need to approach reality and leave superficiality behind. Our spiritual journey may involve a long and complicated process because the revealed reality is sometimes tough to confront and it may contain painful experiences and unresolved problems. A pastor's role in dealing with each individual's spiritual journey is to listen to their revealing story and to sustain their meaning-making process. This may facilitate confrontation with inevitable reality. It is useful to quote from Moyer, who remarks: "Spiritual growth occurs best when the assistance given meets the individual's growing edge" (Moyer, 1989, p. 18). We believe that what he suggests here may sometimes happen in pastoral ministry.

It is necessary, at this point, to explain factors or foods of spiritual growth. Cabot & Dicks (1936) suggest five categories of the foods for spiritual growth: "Love, learning, beauty, service, and suffering well borne" (pp.16-18). These five categories are practically useful and I shall suggest "reconciliation" which integrates them. Reconciliation is an anthropological theme as well as a dogmatic theme in theology. I believe this is a very important theme, especially for dying

patients and long-term hospitalized patients who have chronic illnesses. In an acute care system, most patients receive medical treatment or surgery to recover and fight against illness. They hope not to be hospitalized long and are usually discharged at a certain point. Hospitalization is regarded as a process enabling them to go back to a normal condition and a regular routine in their lives. On the contrary, a dying patient and a chronic patient do not have the same image of recovery. It is difficult for them to expect and hope that they will be discharged from a hospital or released from illness.

We do not mean that a patient who is diagnosed with a terminal illness and has a limited time to live does not have any hope or will to survive and does not fight against the illness. It is quite normal that a terminally ill patient and their families do not give up on his or her life even if the medicine cannot do anything positive for recovery. As long as we live, we keep holding onto our hope for life.

When we observe a patient's reaction to the fact that he or she cannot survive much longer, it is still useful to refer to the classic Kübler-Ross theory, the five stages of the death and the dying process. The five stages begin with denial and anger and proceed to bargaining and depression, and end up with acceptance. She explains about the fifth stage of acceptance as follows: "Acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for 'the final rest before the long journey' as one patient phrased it" (Kübler-Ross, 1997, p. 124).

We may imagine a severe condition in which a patient is physically and emotionally exhausted with all the crises mixed with pain, fear and anxiety. From this point of view, acceptance does not necessarily promise peace to a dying patient, and so I suggest the stage of "reconciliation." This Reconciliation is premised on understanding and acceptance, but "acceptance" is different from the one Kübler-Ross suggests. Reconciliation occurs when we are understood and accepted by the other as well as we understand and accept the other. We have a peace and joy in being understood and accepted. Reconciliation requires a mutual approach and a meaningful interaction between the ones concerned. We need to reconcile ourselves with oneself, the other (especially God and our significant others), illness, destiny and time.

Although illness, destiny and time are not tangible personal entities, they can be objects of reconciliation because they interact with one's life as if they were. We should note that it is still a worthwhile challenge for dying people to accomplish reconciliation with others even if they are unlikely to recover. The great possibility remains for them to grow spiritually through the whole process of reconciliation.

Through my discussion, I found that spirituality is like a silent pond which responds to our actions and thoughts. Spirituality is our reflecting on our physical and mental activities, and its response tells us how our activities work and make sense in our lives. Such spiritual interaction is necessary for us to make our lives meaningful.

In Chapter Two, we have examined a pastor's role and actions as we reflected on hospitalized patients' evaluations of pastors' hospital visitation. We found that prayer was the most common pastoral action. We also found that the pastor's spiritual sensitivity was highly expected by the patients. It is our understanding that the pastor's prayer is most effective when the pastor offers and prays for the patients after having carefully listened to them and understood their personal concerns.

The pastor's presence combined with significant pastoral actions impacts on the patients and helps them to realize that God cares for them. The ministry of presence is an important pastoral action to the sick, and it reminds the patients that the pastor visits them as a representative of God.

A pastor shows his or her spiritual sensitivity through his or her presence and actions. Our reflection on patients' dissatisfaction of the pastor's hospital visitation showed how important the pastor's spiritual sensitivity was. The pastor needs to know that the pastor works for the sick in the role of spiritual caregiver. The pastor needs to reflect on his or her action to improve his or her spiritual sensitivity.

We pointed out a positive aspect of illness as an opportunity for spiritual growth. Our explanation of illness by the Japanese way of writing helped to understand the spiritual aspect of being ill. Sustained by a compassionate pastoral visitor, a patient may grow in spirit even if the patient is unlikely to recover from his or her illness.

We suggested "Reconciliation" as a factor for spiritual growth. Reconciliation is an important task, especially for the dying patients. They need to accomplish a reconciliation with their significant others in order to die in peace.

In the next chapter, we will discuss pastoral care in Japan as I begin to present my personal experience in visiting hospitalized parishioners. I will reflect critically on my experience and interpret the present situation in hospital pastoral visitation, compared to my experience in Canada. Then, I will suggest some factors in Japanese society that may cause pastors difficulties in their hospital ministry.

III. Pastoral Care and Practice in Japan

A. Hospital visitation and the pastor

I will begin this chapter by presenting my personal experience as a parish minister in Japan.

After I had graduated from theological seminary in Tokyo, I served two churches as a senior minister for ten years. They were located in rural areas, one in the western part of Japan, the other in the eastern part of Japan. Although active church members numbered thirty to forty people on average in each church, I had many occasions to visit sick parishioners in their homes and hospitals because the majority of the members were senior citizens. Most of the hospitals in Japan do not have pastoral care services except for a small number of Christian oriented hospitals. Pastors and other religious people are not exempted from hospital rules and regulations in visiting the sick. They are not allowed to visit sick parishioners except during regular visiting hours even if parishioners or their family members request their pastors or lay representatives to visit. For example, when I visited a hospitalized parishioner who was in a coma, visiting time was only five minutes for each day regardless of the number of visitors. I remember that one of the patient's daughters was frustrated and complained that she was not able to see her father in the intensive care unit because another, unexpected visitor spent all the allowed visiting time. She was a Christian and a medical school student. She knew me well and appreciated my pastoral visit to her father. I do not forget the scene at midnight when I saw his wife working alone to clean up his room in the hospital without having enough time for her grieving after her husband's death. As soon as I arrived at the hospital and told her how much

she did well for her husband for six months, she started crying and expressed her grief. I was a mere visitor from outside and so did not have any communication with the hospital staff.

Hospital staff do not recognize that pastors or religious people are important human resources in caring for the sick. Some doctors and nurses are becoming aware of the importance of the spiritual aspect of human life in caring for the sick. They are changing their stance on medical professionals as they reflect on their health care systems and on their approach to the sick. They, however, are still defensive about including pastoral care services in the medical care system.

I will suggest some reasons why they are still defensive about pastors and religious people who are willing to work for the sick in the hospital.

Firstly, there have been different historical processes of hospital foundations and a different tradition of medical institutions between Japan and North American and European countries. Many hospitals in North America and Europe were founded with a Christian mission or denominational background. As the English word hospital suggests the meaning of hospitality, the hospital has been founded upon the purpose of providing warm hospitality to the sick and the sufferer. In other words, the hospital has had a belief or philosophy since its foundation. Based on a belief or philosophy, the Western hospital has developed and organized its medical care system to provide better medical treatment.

By contrast, most hospitals in Japan were not founded upon any religious principles. The whole medical care system in Japan has been developed without any religious influence. We may say that this difference is

a big problem for clergy trying to pursue pastoral care and practice in Japanese hospitals.

Secondly, hospital medical staff depend mostly on their medical skill and knowledge in caring for the sick. They are not educated to cooperate with specialists other than medical practitioners. In the past few years, some professors and teachers associated with medical education have strongly recommended adding death education or thanatology to the curriculum in all medical schools. They acknowledge that medical school students increasingly need to learn more about human life from a broad point of view as well as from medical science. They, however, do not value the role of the pastor or religious people in medical practices. I assume that most medical school students do not have any chance to learn about human spirituality from a religious point of view at their schools. Such an educational problem is correlated to the first problem, as I presented above, that most hospitals in Japan have been developed without religious influence.

Thirdly, in general, many Japanese people are reluctant to believe in a specific religion. They do not want to commit to a specific religion or to religious people unless they need to do so. Most hospitals in Japan do not offer pastoral care services, because patients are indifferent to such services or have no idea about pastoral care from religious pastors, even though some of these patients remain alone and helpless in crisis. Even some Christian oriented hospitals do not hesitate to say that they do not rely on any specific religion for the care of these patients. They do not intend to positively utilize religious resources and pastoral care services to enhance patients' health care. It is my observation that they are totally inexperienced in utilizing such

resources and are afraid of Japanese patients' reaction to religious activities in hospitals.

Finally, I want to consider the role of Christianity and of the Christian church in Japan. I want to state some characteristics in modern Christianity and the Christian churches in Japan. Christianity once had a boom in Japan, in particular after World War II, because it made a great impact on those who lost the values and beliefs that they had held. The war was over—lost—so they struggled how to maintain their own self-identity which had been so influenced by nationalism. Christianity exercised an "intellectual" influence over the minds of those people and gave them opportunities to rethink their older values and beliefs.

By "intellectual" I mean some characteristics of many Protestant churches in Japan. They were formed originally during Meiji times[1] by foreign missionaries who were good examples of Christian faith. The focus of their mission was the conversion of as many Japanese people as possible to Christianity. It has been their tradition to put weight on the interpretation of the Bible and on the preaching of the Gospel. They tend to depend much on intellectual interests and curiosity for an understanding of Christian faith. This is somewhat natural in the sense that Christianity is preached in a different religious context. A problem is that they have not put as much emphasis on pastoral care and practice as they have on biblical interpretation and dogmatic theology. I do not mean that they are not interested in pastoral care and practice, but that they put heavy emphasis on academic interests and curiosity compared to their interests in pastoral care and practice.

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[1] The Meiji times: 1868-1912 in the reign of Emperor Meiji.

In short, they have not studied and developed pastoral theology adequately in order to engage in ministry in the health care setting. Frankly speaking, hospital chaplains and other chaplains such as school chaplains do not get a positive evaluation from such church people, and especially not from parish clergy. The parish clergy do not recognize the role of hospital chaplains and school chaplains who are working in a "different" context; the role of chaplains is not primarily to convert patients and students to Christianity. Parish clergy and their congregational members are not quite conscious of institutional ministry. Such ignorance may also contribute to a disconnection or miscommunication between religion and medicine.

For cultural and historical reasons, then, pastoral hospital visitation is not accepted. Although my brief discussion here leaves room for a variety of interpretations and needs further consideration, it does, however, help to address a fundamental problem, which will be discussed in the following section, that the Japanese people are reluctant to believe in a specific religion.

B. The role of religion and the understanding of death in Japanese society

In the previous section, I discussed the practical problem that clergy face difficulties in hospital visitation. I considered some reasons why such difficulties occur. In this section, I will focus on a religious problem underlying Japanese society and the Japanese people, and will look more carefully into the connection between this problem and the difficulties of hospital pastoral visitation. I should say, however, that the fuller study of this religious problem lies outside the scope of this paper. Therefore, I will

concentrate on the role of religion and the understanding of death in Japanese society.

I will begin my discussion with an interesting quotation about religion in Japan. In the series of Kodansha Bilingual Books, *Talking about Japan-Q&A* states:

> When one asked Japanese, "What's your religion?" many of them, excluding Christians and followers of new religion, would answer "I have no religion." However, when asked "What is the religion of your family?" they might answer "Jōdo sect of Buddhism," or "Nichiren sect of Buddhism." That means, the religion that each family has had since ancient times for the purpose of worshipping their ancestors has stayed with the household. Often times it has little to do with one's religious faith. (Kodansha International Ed., 1998, pp. 181-183)

This religious sense might sound funny to someone not familiar with Japan, but such a situation is quite common for many Japanese. It is not a contradiction when some Japanese say, "I do not have my own religion, but I have a specific religion in my family." This means that such an individual does not believe in a specific religion personally, but he or she does attend religious events or activities for "worshipping" ancestors in Buddhist temples or attend wedding ceremonies and child blessing ceremonies in Shintō shrines. Buddhist temples maintain cemeteries, and families go there to visit their ancestors' graves. Commonly, some family members called *danka* support the temple financially. Even if one does not have a living faith in Buddhism, he or she has to maintain a connection with the temple which administers his or her family's ancestors' grave.

Japanese Buddhism is often described as "funeral-Buddhism," which means that the major role of Buddhism is to conduct funerals. This description is ironic because it implies that Buddhist priests do nothing more than conduct funerals. Toshihiro Ama, a professor in Japan, who is studying the meaning of religion for the Japanese people, makes several important statements on this problem in his book *Nihonjin wa naze mushūkyō nanoka* [Why do the Japanese people not have a specific religion?]. He says that "funeral-Buddhism" is a compromise with a natural religion which still exists among the Japanese people (Ama, 1999, p. 66). In his study, the word natural religion is used to differentiate it from a religion which has a founder, a canon and a religious organization. Natural religion has occurred naturally without a specific founder, and has lasted from generation to generation (Ibid., p. 11).

Ama describes the role of funeral-Buddhism as helping ordinary people gain relief from anxiety related to death. He points out that many Japanese people may accept without worry that they do not have a specific, personal religion. Funeral-Buddhism promises to ensure peace to people after their deaths. Therefore, they do not have to worry about choosing a specific religion during their time of living in this world (Ibid., p. 64).

Let us consider another statement on religion in Japan. Munesuke Mita, a social scientist in Japan, remarks as follows (my translation):

> Religion in Japan does not break off a connection between the dead and the living. The dead person has regrets regarding this world and the living person has regrets regarding the dead. Religion is recognized in the communication between the dead and the living. It is

> a humanistic religion; the world as ruled by an absolute God is not known. (1984, p. 154)

Mita's first point, that religion does not break off a connection between the dead and the living, may be more understandable to Westerners if I describe certain Japanese traditions and feelings. The deceased are communicated with not only at their graves but more often in the home, at the "butsudan" where the deceased person's Buddhist name is inscribed on a small upright tablet in front of which are placed flowers, cooked rice, and other presents. Thus the living treat the dead as still alive. The communication is in the form of conversation and is assumed to be two-way. The living reports what has happened in daily life, to children and grandchildren, etc. Especially in time of trouble the family will report to the deceased, and when a problem has been resolved, the ancestors are given some credit—that is their side of the two-way communication.

Mita's ambiguous comment about "regrets" implies a number of things, the most straightforward of which is that there are always some activities and relationships not completed in life which the dead person regrets, while those living regret his or her not having been able to enjoy such completion, as well as regretting his or her absence.

Throughout all such activities and traditions there is a feeling of continued family unity. Despite deaths, the family circle remains unbroken. This comes out again in Mita's third comment, regarding God.

What Mita said suggests that the Japanese people's sense of an extended family circle including ancestors constitutes a primitive religious faith. Mita said, "If we name God as a Hebrew God, then the Japanese people,

basically, do not need such a category as God" (Ibid.). A primitive religious faith may be said also to exist in the tradition of funeral-Buddhism. So they do not need a specific religious faith or an absolute God in order to understand death. In addition, as Namihira points out, there is very little variation in how a Japanese learns about the culture of death—a ritual for the dead which is a group-centred activity has been developed (1990, pp. 37-38). She also notes that when asked "What do you think about your own death?" most Japanese have trouble verbalizing an answer, probably because they have never thought in those terms because of a well developed death culture expressed in the traditional death rituals. They have not developed much consideration of death in the abstract, except for some religious people after the Meiji times (Ibid., pp. 38-39).

It is important for the Japanese people to maintain the ties of blood—a family, an extended family and ancestors—rather than to communicate with an absolute God. This is a key to how the Japanese people understand and accept death. They have peace in the communication with their family. Not knowing death in the abstract, they need no relief from a fear of death. Understanding death in terms of maintaining love for each other and of the warm ties of the family, they prepare to accept their own death in the future. They come to understand it as they participate in rituals for the dead such as funerals and yearly religious activities in Buddhist temples related to worshipping ancestors. In other words, they have the chance to think frequently about their own mortality in conjunction with the ties of the family. We may say that such religious rituals also mean a lot as family rituals. In fact, they gather at a parents' house or a temple in their hometown for an

annual religious event every summer. This helps them realize that they are firmly embedded in the ties of their extended family.

In modern Japanese society, however, they are being challenged in that they face rapid changes in family relationship and in family structure, accompanied by changing social systems and structures. People need to reconsider their traditional understanding of life and death in order to cope with such a critical situation. In particular, they are being challenged to enhance their quality of life despite an excessive dependence on the latest biomedical technology.

It is of fundamental importance that religion, religious people and pastors take responsibility for answering this challenge and intervene positively with such problems. We realize that pastors have difficulties working with hospitalized patients and with providing spiritual care for them. Kippes, who is a native of Germany and a supervisor in clinical pastoral education in Japan, critically says, "Modern Japanese society has an allergy to any religion, not supporting and assisting it" (1991, p. 391). According to his personal experience, he was refused his comment on spiritual care for patients in a hospice when he told it to a director of some TV program, because the director sensed his comment was strongly religious (Ibid.).

Although "spirit" is in common use, the term "spirituality" is not. People do not use it so often. Even religious people and scholars are struggling with providing a suitable Japanese translation for spirituality. That means they do not really know how to adapt this term to the different religious contexts. I really think that pastors need to have a better understanding of spirituality in dealing with the sick. This is a key to providing good pastoral

care for the sick. It is our challenge to improve our sensitivity to our patients' spirituality, remembering the Japanese sensibilities.

Although my discussion above cannot be exhaustive, I hope it is suggestive of the scope of the problem of being a hospital chaplain. Let us turn next to drawing some conclusions.

IV. Conclusion

We have looked at some aspects of pastoral visitation generally in Chapter One, and at more specific, practical considerations of the pastor's role and activities in Chapter Two. In Chapter Three we considered some particularly relevant socio-cultural conditions in Japan. Let us now try to weave these threads together somewhat more.

Pastoral visitation to those who are sick is an important pastoral ministry. No matter where the sick person is, a pastor visits those expecting the pastor's visit.

I do not forget what a patient's granddaughter told me— that she saw her grandmother, who was 95 years old and taken in an ambulance because of her poor condition, become more stable mentally after I visited her in the hospital. I did not expect such words at all from her family, because I thought I could do nothing meaningfully for the patient during my visit. What I did for her was to be with her for a little while and to pray with her while holding her hands. I remember her saying "thank you" when I was going to leave her room. As I reflect on my experience, I realize what Young (1954) pointed out—the symbolic nature of the pastor's role and its significant influence to the patient.

As we discussed in Chapter one, a pastor who feels a specific call to the ministry to the sick responds to this call both inwardly and outwardly. I hear the call to pastoral care of the sick, especially of hospitalized patients and those who are dying. Although I recognize many Japanese people do not need a religious support from the pastor, I cannot neglect voices from those who are strangers, and are crying for help. How does the pastor respond to those people and provide care suitable for them? In other words, how can the pastor be honest to his or her call to the pastoral care of the sick?

The most important thing is that the pastor clearly realizes his or her role in caring for the sick. It is helpful to remember what we quoted from Holst in order to clarify our point on the role. He says, "Role is a combination of external (imposed) and internal (self) expectations" (Holst, 1985, p. 46). We should respect both our desire to serve patients and the patients' expectations of the pastor.

We found that the pastor has a special representative role in visiting the sick. The pastor visits the sick as the representative of God and serves them in Christ's name on behalf of his or her congregation. This is definitely a given role, even if not a pastor's desired role. The pastor, however, has to have a conviction that he or she goes out to serve the sick as the representative of God. This may contribute to the symbolic nature of the pastor's role as the pastor visits the sick.

In Chapter two, we considered the role of the pastor and the pastor's activities in visiting the hospitalized patients from the patients' point of view. We used the research studies in professional journals. We found from these studies that the most common pastor's action to the sick was praying, and that

the hospitalized patients placed a high value on the pastor's spiritual sensitivity. In the study of the breast cancer patients (Johnson & Spilka), we found that "being understood" had exceptional meaning for the patients. We may say that patients feel understood by the pastor when the pastor has a spiritual sensitivity and shows it fully in his or her presence and in conversation. From these findings, we drew our attention to the pastor's actions in the role of spiritual caregiver.

We considered what the significant pastoral actions are in the role of spiritual caregiver as we reflected on patients' negative reactions to and dissatisfaction with a pastor's insensitive actions. Patients, especially those who are afflicted with life threatening illnesses, have fundamental questions about the meaning of their living with such illness. A pastor as a spiritual caregiver has to be sensitive enough to those patients. A compassionate pastoral visitor focuses on the patients' concern, but not on his or her own concern. The pastor needs to realize that the patients are going on with their meaning-making process and to facilitate them to cope with problems arising in that process. The pastor can help those patients with the ministry of presence and the art of listening in interacting with them. We may say that the pastor's presence and listening are the most important actions in the role of spiritual caregiver.

We also discussed the importance of a pastor's awareness of his or her own spirituality. This may affect patients' spirituality and spiritual growth as the pastor interacts with them. The pastor needs to be aware of his or her own spirituality as well as of the patients' and to improve his or her own spiritual sensitivity in dealing with the patients' spiritual journey. Reflecting on one's

accumulated experiences as a spiritual caregiver may contribute to a pastor's improvement in spiritual sensitivity.

Although we admit there are negative aspects to getting ill—changing one's life plan and schedule, having unpleasant physical and mental conditions and facing one's mortality—we have an opportunity for spiritual growth during such conditions. We may gain a new insight into our lives when dealing with illness or hospitalization. In our difficult time of illness, we receive a lot of care from other people. Interacting with those who care for the sick, some patients may gain hope and power to recover from illness. Some may gain peace of mind in spite of extremely serious conditions. Another patient may deepen intimacy with his or her significant others. A family reunion may occur in the time of someone's illness, because family member's attentions are drawn to the one who is sick, and such occasions allow them to approach each other for better communications. We may say that spiritual growth occurs as each patient faces the unique situations that are inherent in one's life. It is a gift for both the pastor and patients to have such an opportunity for spiritual growth. The pastor also gains a new insight into his or her spiritual journey and a fresh awareness of the meaning of life touching the patient's spiritual growth.

In our brief discussion of factors of spiritual growth, in addition to what Cabot & Dicks suggested as the food of spiritual growth we considered "reconciliation". I wish I could have presented a case study to show how important reconciliation is for the dying people and their families to have peace of mind facing the end of life. This theme is worthy of consideration when dealing with the dying people and their family in Japan. When we see a

certain family focusing on the ties of the family, we may find how the family functions as a unit. I often thought about this problem, especially when I saw families facing the loved one's death. I was very interested in observing such families, because I could see the family dynamics—how each family member interacts with each other, who is ruling the family and how the parent's death affects the relationship of children. Family dynamics are disclosed when some family member dies. They recognize that it is time to become involved in the family restructuring as they lose someone in their family. Reconciliation is necessary for such families to accomplish this important family task—the family restructuring.

A pastor will have a serious problem in dealing with the bereaved family if he or she does not admit the importance of reconciliation. The pastor does not necessarily apply a theological connotation to the image of reconciliation that the family has. Even if the dead person is a Christian, it is very common that other family members are not Christian in Japan. I have found, however, that the use of biblical images of reconciliation is very helpful for the bereaved family to imagine how reconciliation works for the family.

What I want to suggest is that we practice our pastoral care of the sick in Japan respecting the cultural uniqueness and characteristics underlying the society. It is my observation that the Japanese people are afraid of being converted to Christianity or other specific religions which have different values and ideas from those existing in our customs and tradition, because they are afraid of being separated from the ties of blood—the unity of the family. They are not afraid of learning from other culture and traditions. It is fair to say that the Japanese people are very curious about knowledge, wisdom

and events in other countries. They have absorbed useful knowledge, wisdom and skills from other countries over centuries when they do not interfere with the national values and identity existing in customs and traditions in Japan.

I do not suggest here that a pastor does not use any religious resources that he or she has when working with patients. In my personal experience, not a few attendees at funerals told me that they were impressed with the pastor's message from the Bible—my message was focused on the deceased's life story in his or her family unity using biblical images of life and death. The important thing is that the pastor takes advantage of every possible opportunity to speak his or her message with compassion and with respect for the other's values and beliefs.

Spirituality is the key term in order to approach patients and to provide pastoral care. My next challenge is how to incorporate spirituality in my practice in the Japanese cultural setting. I need to begin my practice and research in Japan in order to develop my idea about this problem. Western ideas led me into the realities of pastoral care and practice for those who are sick and gave me a new insight into my pastoral ministry. I really hope that this experience becomes a cornerstone in my heart.

Finally, I suggest a few things for a better understanding between North American pastoral visitation and Japanese pastoral visitation.

North American pastoral visitors usually respect the patients' spiritual needs and help them to face their problems and to overcome their weaknesses as growing edges. Such pastors are open to talk about the patients' personal concerns, and sometimes pastors need to have the courage to take risks in order to resolve problems that the patients are confronting.

I think trained pastoral visitors are not afraid of the challenging problems and conflicts arising in the process of intervention with a patient. The self-awareness gained from clinical training may contribute to their openness and readiness to accept whatever the patient brings to them. Another benefit from clinical training is that a trainee learns to interpret him/herself as working together with patients.

Japanese pastoral visitors should have such opportunities to experience clinical training and so to gain openness and readiness for pursuing ministry with the sick. Although they have adequate spiritual sensitivity to the sick, they need to know how to use self-awareness for their practice and to reflect on their experience.

North America, especially Canada, constitutes a multi-cultural society. It is important that pastoral visitors here become more aware of the different expectations of patients from different cultural backgrounds. Canadian pastoral visitors tend to ask many questions. Patients from other cultures may find such questions too direct and personal, and too soon. Also, naturally enough, Canadian pastors may have difficulties coping with patients who do not have an adequate command of English. Even if their English is adequate to speak about their personal concerns and feelings, people from other cultures might not rely much on verbal expressions to reveal their spiritual pain and deep feelings. Canadian pastoral visitors may fail to communicate with those people if they are not able to change their own stance or approaching style. Canadian pastoral visitors need to improve their insight into the patients' inner world which is not revealed in verbal expressions.

We all sometimes need not words but silence and time to touch each other's spirituality.

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