



Impressions of Interfaith Chaplain's Activities among Patients in a Palliative Care Unit: A Semi-Structured Interview-Based Qualitative Study

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Providing spiritual care in light of a patient's religious and/or spiritual background can help improve the quality of end-of-life care. Rinsho-shukyo-shi is a Japanese interfaith chaplain who provides religious and spiritual care to patients. In this study, we qualitatively explore the impressions of patients in a palliative care unit of the activities of an interfaith chaplain in a hospital in Japan. The authors used semi-structured interviews carried out by a male nurse experienced in qualitative and quantitative research in palliative care. The male nurse asked only a few predetermined questions in the interviews, which were conducted from January 19 to December 26, 2018. The interviewees were 15 patients diagnosed with advanced cancer (five men and 10 women; aged 53-81 years), and they were admitted to the palliative care unit of Tohoku University Hospital (the hospital has no religious affiliation). Patients who had spoken to the interfaith chaplain at the hospital at least twice were included in the study. The interviews were digitally audio-recorded, transcribed verbatim, and analyzed. Three main themes were identified through thematic analysis. Resistance varied across patients; no patient felt resistance to the intervention by, or to the presence of, the interfaith chaplain once he/she had spoken with him. Opinions about the interfaith chaplain also varied, with 10 patients claiming that his role was necessary for end-of-life care and beneficial for the chaplain himself. Finally, the patients' religious beliefs varied widely. In conclusion, the interfaith chaplain is deemed helpful by the interviewed patients in relieving their anxieties.

Keywords: advanced cancer; interfaith chaplain; palliative care; religious care; spiritual care
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Introduction

Providing spiritual care in light of a patient's religious/spiritual background can help improve the quality of end-of-life care (Balboni et al. 2010). Research has shown that such outcomes are associated with spiritual care that includes attending to a terminal patient's religion and that of his/her family (Balboni et al. 2007; Becker et al. 2007; Okamoto et al. 2010; Vallurupalli et al. 2012). Aoyama et al. (2017) found that patient satisfaction was high in facilities in Japan with a religious background, and that access to religious clergy was considered an important factor in their satisfaction. Such religious officials as Buddhist monks, Christian chaplains, Shinto priests, and leaders who have

historically cooperated within a single faith can provide spiritual care in light of the patient's religion and spirituality at the end of life.

Healthcare chaplains work all over the world in a variety of settings, including hospices and specialized health-care settings (e.g., cancer centers), to assess and explore religious/spiritual distress in patients that may be manifest or latent (Fitchett and Risk 2009). However, the term "chaplain" is not well known in Japan because a majority of Japanese people claim to have no religious association, with fewer than 30% claiming a faith-based affiliation (The Institute of Statistical Mathematics 2017). Only 1% of the population is Christian. More commonly, chaplains function as "interfaith" chaplains who cater to people in reli-

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gious/spiritual distress and address wider spiritual issues (Cadge 2013). Many Japanese people are spiritual, although they often have no opportunity for a discussion of deep spiritual issues.

Since the Great East Japan Earthquake of 2011, Buddhist monks, Christian pastors, Shinto priests, and leaders of other religions have worked together to provide religious care. This multifaith cooperation established a new model for the Rinsho-shukyo-shi, who is a Japanese interfaith chaplain, featuring education based on the Code of Ethics of the Association of Professional Chaplains and Clinical Pastoral Education. Interfaith chaplains are aware of individual needs relating to religious and spiritual care, and provide support for patients and care providers by listening and through prayer. In Japan, most chaplains are employed in facilities with a religious background, but interfaith chaplains work in facilities without any religious affiliation or background. A certified interfaith chaplain was employed for the first time in Japan in 2016 at Tohoku University Hospital, which has no religious background.

To the best of our knowledge, no study has to date explored impressions formed by patients in palliative care units in Japan on the activities of interfaith chaplains because this role is new. A deeper understanding of these impressions, based on patients' conversations with the interfaith chaplain, may help improve the planning and implementation of end-of-life care. This study, therefore, explores this subject.

Methods

Design

This study is a qualitative exploration using individual, semi-structured interviews with patients diagnosed with advanced cancer in a palliative care unit in a university hospital in Japan.

Participants and setting

The cancer patients admitted to the palliative care unit were approached for participation in the study. The inclusion criteria were that the patient needed to have been 18 years of age or older, hospitalized in the palliative care unit, to have had at least once talked to the interfaith chaplain, and to have secured written informed consent from his/her doctor. The criteria for exclusion were the diagnosis of delirium and difficulty in participating in the interview because of mental or cognitive problems. The patients were recruited from a single site of the palliative medicine department of Tohoku University Hospital, which is not affiliated with any religious or faith-based denomination. The recruitment was conducted through convenience sampling, and was carried out until theoretical saturation was reached.

Interfaith chaplain's background

The Rinsho-shukyo-shi is a Japanese-style interfaith chaplain educated according to the Code of Ethics of the

Association of Professional Chaplains and Clinical Pastoral Education, which encompasses practical pastoral education rather than theological education as the chaplains come from different theological contexts, or even atheist practice. Interfaith pastors are common in clinical settings in the United States, Canada, Australia, and New Zealand (Isomae and Kawamura 2016). The idea underlying the role of interfaith chaplains is multifaith cooperation among leaders of Buddhism, Shinto, Christianity, and other religions, and avoiding proselytizing to people who have no religious affiliation. The interfaith chaplain had at the hospital in question had completed the requisite education curricula and been certified. He had no experience in the care of patients with advanced cancer, although he had volunteered in the hospital's palliative care unit before being employed as an interfaith chaplain.

Interfaith chaplain's activities

Information pamphlets about the interfaith chaplain, who was also a monk, were available to patients and visitors in the patients' rooms. Doctors and nurses also provided patients with information about the interfaith chaplain's activities: that he could listen to patients and help relieve them. When a patient wanted to talk to the interfaith chaplain, he visited their room and provided religious and spiritual care by listening to not only their spiritual distress, but also their physical and psychological distress.

Data collection

Face-to-face, qualitative semi-structured interviews were conducted with patients by K.M., a male nurse with experience in qualitative and quantitative research in palliative care. We selected him as the interviewer to reduce bias in sampling because he was not employed by the department, and had no clinical relationship with the patients or the interfaith chaplain. The interview with each patient took place in their room, where they were alone with the interviewer. Each patient was interviewed once, and the interview was kept brief to avoid taxing the patients. The interviews were based on an interview guide (Table 1), which in turn was based on agreement by experts on palliative medicine, nursing, and spiritual care because no conceptual framework was available from past work, especially for Japan. The patients were aware that the interviewer was a nurse. All patients provided written informed consent prior to their interviews.

Table 1. Main interview topics.

1. How was it to talk with the interfaith chaplain?
2. Were you initially resistive in talking with the interfaith chaplain?
3. Did you change your feelings and ways of thinking with talking with the interfaith chaplain?
4. Do you believe in any particular religion?

Data analysis

The interviews were digitally audio-recorded, transcribed verbatim, and analyzed. Three authors (Y.H., M.A. and K.M.) read and analyzed each interview transcript. The interviews were analyzed using inductive thematic analysis in six stages (Nowell et al. 2017): familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

Ethics

We recognized that the interview process had the potential for causing distress among the patients by making them think about their own death. Therefore, a support team including each patient’s primary physician provided mental care after each interview if the patient had requested it. The Helsinki Declaration was followed. The study was approved by the ethics committee of the Tohoku University Graduate School of Medicine. (2017/11/08).

Results

In total, 144 patients talked to the interfaith chaplain during the study period. However, most of them were excluded because they had since died or had difficulty in speaking. Sixteen patients were eventually approached for this study, and 15 (93.8%; five men, 10 women; M = 66.5 years) diagnosed with advanced cancer were enrolled until theoretical saturation was reached (Table 2). The interviews were conducted from January 19 to December 26, 2018. They were, on average, 6 minutes long, and were all performed in the patients’ rooms. The mean number of times the interfaith chaplain spoke with a patient before the was 4.1 (range: 2-9).

By examining impressions of the activities of the interfaith chaplain formed by patients in the palliative care unit, their religious beliefs, and their spiritual distress, three main themes were identified: (1) resistance, (2) opinion of the interfaith chaplain, and (3) religion. These themes and their subthemes are shown in Tables 3 and 4.

Theme I–Resistance

Three subthemes were identified in Theme I: (1) resistance to religion, (2) disturbance, and (3) no resistance.

Resistance to religion: Three patients (D, F, and I) reported feeling resistance to the term “religion.” They had assumed that religion meant, not Shinto or Buddhism, but rather “cult religion,” and that it should thus be avoided.

At first, when I heard the name of the interfaith chaplain, I thought that his objective was to spread his religion (Patient D).

Since religion is not positive for me, a monk is also not positive for me (Patient F).

Disturbance: Two patients (H and M) were confused about having a “monk” at the hospital because monks in black robes reminded them of death, as they are associated with funeral practices in Japan.

I was surprised to see a monk in the palliative care

Table 2. Patient characteristics (n = 15).

	n	Mean	Range
Sex			
Women	10		
Men	5		
Age		66.5	53-81
Cancer site			
Lung	2		
Pancreas	3		
Bile duct	1		
Ovary	2		
Sarcoma	1		
Liver	1		
Kidney	1		
Uterus	1		
Rectum	1		
Stomach	1		
Peritoneum	1		
Suicidal ideation			
Yes	3		
No	12		
Marital Status			
Married	8		
Separated	1		
Widowed	3		
Never married	3		
Housemate			
Yes	13		
No	2		
Times of talking with a chaplain before interview		4.1	2-9

unit (Patient H).

I did not know that he was listening to me and trying to relieve [me] (Patient M).

No resistance: No patient expressed feeling resistance to subsequently talk to the interfaith chaplain once they had initially spoken.

Because my brother was indebted to monks, I had no resistance to him. (Patient L)

I did not think that the existence of the interfaith chaplain was special. (Patient O)

Theme II–Opinion of the interfaith chaplain

Three subthemes were identified in Theme II: (1) the role of the interfaith chaplain, (2) the relationship between the interfaith chaplain and the patient, and (3) the character of the interfaith chaplain.

The role of the interfaith chaplain: Ten patients (B, D, G, H, I, J, K, L, M, and N) had various opinions on the importance of the interfaith chaplain. They thought that he was necessary for end-of-life care. However, before they had talked to him, they did not know what the interfaith chaplain would speak about.

I imagined that the interfaith chaplain would talk with

Table 3. Themes identified through interviews.

Theme	Subtheme
Resistance	resistance to religion disturbance no resistance
Opinion about the interfaith chaplain	the role of interfaith chaplain the relationship between the interfaith chaplain and patients the character of the interfaith chaplain himself
Religion	religious beliefs view of religion

Table 4. Answers to the three main themes.

Patient	Age	Sex	Resistance	Opinion	Religion
A	68	F	–		
B	65	M	–	Ro/Cha	
C	81	F	–	Cha	B/VR
D	61	F	+	Ro/Re	
E	57	M	–	Cha	VR
F	76	F	+	Re/Cha	B/VR
G	57	F	–	Ro/Re/Cha	
H	76	F	D	Ro/Re/Cha	VR
I	77	M	+	Ro/Cha	
J	53	F	–	Ro/Re	B/VR
K	54	F	–	Ro/Re/Cha	VR
L	71	M	–	Ro/Cha	
M	65	F	D	Ro/Re/Cha	
N	70	M	–	Ro/Re	B
O	67	F	–	Re/Cha	B

No one reported a belief in any particular religion.

M, male; F, female; D; disturbance; Ro, the role of interfaith chaplain; Re, the relationship between the interfaith chaplain and patients; Cha, the character of the interfaith chaplain himself; B, mentioned Buddhism; VR, view of religion.

patients who have come close to death or could not avoid death, and he would be willing to offer hope for the future. (Patient B)

I was able to talk with confidence because there was something in common with what he was doing and what I was doing. (Patient D)

I thought that he was trained at a severe scene on life and death. (Patient L)

The relationship between the interfaith chaplain and patients: Nine patients (D, F, G, H, J, K, M, N, and O) viewed their relationship with the interfaith chaplain as positive because he had sympathized with them and taken time to listen to them.

I was relieved by [him] listening to me, although my disease would not heal and the problem would not be solved. (Patient F)

To talk with a religious person was interesting for me because there has only been an opportunity to talk with a monk in the past when someone has died. (Patient G)

He talked to me, taking a long time to talk and think, so it was comfortable to talk to him. (Patient J)

The character of the interfaith chaplain: Eleven patients (B, C, E, F, G, H, I, K, L, M, and O) felt the interfaith chaplain had attractive characteristics; they thought he was calm, pure, and intelligent. They were conscious of him as both a monk and a young man who listened to them.

I met with him three or four times; he started with a greeting each time, so I thought that he was a serious and sincere person who could care for people. (Patient B)

Since I did not know he was an interfaith chaplain, I thought that the hospital and the monk had collaborated. I had a chance to talk with him and I just spoke with him a little. (Patient H)

Theme III—Religion

Two subthemes were identified in Theme III: (1) religious beliefs and (2) view of religion.

Religious belief: No patient reported a belief in any particular religion, although five mentioned Buddhism.

I do not particularly believe in a specific religion such as Christianity or Islam. (Patient E)

I and my husband visit the grave, but Buddhism was not the subject of faith. (Patient F)

View of religion: Six patients (C, E, F, H, J, and K) who claimed to have had no religious affiliation reported having been influenced by several religions.

Although I have been involved in various religions, I think that the Japanese do not have any religion after all. (Patient C)

The degree of influence from religion is difficult [to determine]; however, I may have been influenced by Christianity, Buddhism, and Shinto. (Patient E)

Discussion

This study is the first on interfaith chaplains in Japan. The results indicate that while some patients felt some initial resistance toward the concept of religion, this diminished after talking to the interfaith chaplain at the hospital; furthermore, they felt that the chaplain's intervention did

not cause them harm, and made some patients feel comfortable.

The interfaith chaplain was able to comfort some patients by allowing them to talk about their feelings, and by “listening” intently to them; no negative outcome was reported by the patients after intervention by the interfaith chaplain. They also found it helpful that he had more time to talk to them than the doctors and nurses, who were often too busy to listen. Based on the interview data, the patients who had felt an initial resistance toward the chaplain claimed that this lessened once they conversed. “This is a palliative care ward, so I knew that he was the one who listened to patients in distress” (Patient D). “I did not tell others about my illness, but for the first time, I was able to talk to someone else” (Patient F). The following are some possible reasons for the initial feelings of resistance to the chaplain reported by some patients: first, a majority of Japanese people claim to have no religious affiliation, but they are not atheistic either. They visit family graves on a regular basis and hold funerals even though they claim to have no faith. Furthermore, most regard the practice of visiting graves and funerals as a custom, and not a religious act (<http://www.jsri.jp/English/ojo/2011/taniyamaexcerpt.html>). Thus, despite the popularity of such practices in Japan, people still feel some resistance to religion. Second, Shinto and Buddhism have been combined with ancestor worship, which has come to be associated with funeral practices (Taniyama and Carl 2014). Therefore, monks in black robes often remind people of death, and they are seen as a “bad omen.” As described in the *Kojiki*, Japanese people have perceived the world of death in the image of darkness and ugliness, and since ancient times have been afraid of death. Therefore, they avoid things that remind them of death (Kitayama 2010). However, the patients became less resistant once they had talked to the interfaith chaplain, and most subsequently expressed positive opinions concerning the importance of such chaplains and their activities. Third, the hospital considered in this study has no religious background, and the patients have historically had no opportunity for contact with religious resources other than the interfaith chaplain. Therefore, they were initially resistant to talk to someone unfamiliar. Furthermore, Japanese people consider chaplains to be experts in life and death. Therefore, even if the interfaith chaplain had not provided religious or spiritual care, the patients’ initial resistance might not have been a problem as long as they spoke to him once (Ohmura 2018).

While other studies have been conducted on chaplains in various countries (Handzo et al. 2008; Sinclair and Chochinov 2012), and while interfaith chaplains are common in many countries (Liefbroer et al. 2017), it is important to note that their activities differ from those of conventional chaplains. That is, because a majority of Japanese people claim to have no religious affiliation, with less than 30% reporting a faith-based association, it is important for interfaith chaplains to attend to customs and popular beliefs.

However, controversy has arisen in other countries around the need to screen for distress caused by the role of religion and spirituality (Fitchett 1999; Fitchett and Risk 2009).

This study has some limitations. First, the data were drawn from a single center and interactions with one interfaith chaplain. There might have been a possible conflict of interest between the interfaith chaplain and the nurse researcher, although the latter was not employed by the department and had no clinical relationship with the interfaith chaplain. Further research can include interviews involving interfaith chaplains from other institutions. Second, the interviews lasted only 6 minutes on average to avoid burdening the patients. Although each interview was terminated when we thought that the relevant themes had been sufficiently saturated, a longer interview may be more adequate to obtain more information about the patients’ impressions. Third, intervention by the interfaith chaplain might have led to harm. Such harm can be identified by including a topic that addresses harm in the interview. Fourth, there was a selection bias inherent in the inclusion of only patients who had experienced an intervention by the interfaith chaplain. This means that the patients considered might have felt less resistance than patients who had not previously interacted with the interfaith chaplain.

In conclusion, this study reported impressions of interventions by an interfaith chaplain formed by a small number of palliative care cancer patients in a hospital in Japan. The intervention was thought to be helpful in terms of offering comfort to the patients, and did not cause them harm, although some reported feeling an initial resistance to the prospect of hearing about “religion.” While the majority of Japanese people claim to have no religious affiliation, this does not mean that religious care is unnecessary for them. Rather, it is necessary to emphasize spiritual care that recognizes a patient’s religion and spirituality while sharing a common understanding of their folk faith. It is thus essential to continue developing appropriate spiritual care for minority patients, like the Japanese people who claim to have no religious affiliation.

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Conflict of Interest

The authors declare no conflict of interest.

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