Scientific Contribution

Significance of the Narrative in Spiritual Care

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Abstract

Spirituality is a phenomenon that is thought of “not as religion itself but as religious.” With the word “spiritual”, we can talk about the meanings of death and life without being bound to a specific religious tradition; thus, the attention to spiritual care is increasing in the area of end-of-life care. Spirituality can be thought of in two aspects, namely nomothetic and ideographic; the latter regards every experience of patients as being unique and non-replicable. This posture is common with the narrative approach in the end-of-life care. Moreover, the characteristic of creativity present in the narrative allows one to create “a new story” without being bound to a particular conventional religious story.

Keywords: Narrative, Spiritual Care, Spirituality, Religion, End-of-Life Care

1. Introduction

In recent years, particularly in the field of end-of-life care, interest in spiritual care has been growing, and there have been more and more discussions about the relation between religion, spirituality, and medical care (Kamata [2014a] [2014b]). Along with the term “spirituality,” these discussions frequently feature the key word “narrative” with regard to care, as the development of a narrative as a way of thinking may have the potential to open a new field in patient care (Eguchi et.al. [2006]). While focusing on the relation between spiritual care and the “narrative,” this article considers the meaning of the “narrative” in spiritual care. There is surely a great deal of overlap between the two. However, a “narrative” is not inherently “spiritual”, and “spiritual” care does not necessarily have a “narrative.” This article reviews the possibilities that are opened by the joining of the “narrative” to spiritual care.

First, this article summarizes the use of religion and spirituality in conjunction with medical care. Unlike premodern societies, many modern societies no longer assume that religion is the most important factor in health or that we are mystical beings; however, we do at times mix spiritual care with medical care (Ferngren [2012]). It is important to avoid the assumption that religion and spirituality are opposed to medical science, though some contemporary people presuppose that the whole point of modernization has been to stand in opposition to religion and spirituality. In other words, medical practices based on religious and mystical thinking as well as modern medical care based on science are not necessarily utterly divided, and religion and mystical thinking must not necessarily be excluded from medical care.

Two approaches to this issue have had a powerful impact. The first approach is the science-centric belief that medical care is pure science while religion and the mystical are antithetical to science. The second approach is aptly labeled as secularism, i.e., the belief that religion should be excluded from public areas such as medical care and public education.

Why, then, has the public’s attention returned to religion and spirituality in recent years? We can easily look back on this process. The process has varied according to region as well as the field of study, but overall, this shift in critical thought began around the 1960s with the movement called “postmodernism,” which was a reaction to excessive modernization.

In the field of modern medical care, the book “Medical Nemesis: The Expropriation of Health” by Illich [1979] popularized the concept

of "iatrogenic disease." The wide range of issues that have arisen with the development of modern medical technology has also reawakened the public to the importance of religion and spirituality. For example, questions concerning the nature of death may come up any time an organ transplant is performed on a brain-dead patient. Religious and spiritual thought is necessary to address such questions (Y. Ando [2014]).

To prevent confusion, let us define certain terms from the start. First is the word "spirituality." The definition of this term varies with the disputant, and the variety of definitions is a characteristic of spirituality itself. One definition that wins broad consensus, however, is "that which is religious but is not religion." Many disputants think that any religion excluding elements such as organization and systems can also be called spirituality (O. Ando [2007]). Yet, a strict definition of "religion" is also difficult to achieve, and thus, some suggest defining spirituality without referencing religious systems as ambiguous. For example, Swinton collected and analyzed the results of various studies confirming that spirituality does have a positive effect on health, but he first stated that it was difficult to argue about this effect persuasively because the definition of spirituality was so ambiguous (Swinton [2012: 102]).

While various understandings of spirituality are permissible, there must be a common definition of spirituality to some degree, or no meaningful discussion concerning spirituality would be possible, not to mention its growing popularity. Therefore, in this article, let us propose a working definition for spirituality, as has been hypothesized for religion as well (Clifford Geertz's definition will be introduced and considered later in this paper). A religion can be defined as a phenomenon containing elements related to larger, more encompassing thoughts (such as the world-view, a view of humanity, and some notion of the ultimate), as well as elements related to actions (such as expressing courtesy, asking for alms, and praying), and elements related to groups (such as religious societies and communities) coming together and sharing a system of understanding life and death or of thoughts about eternity and life after death, as well as a system of relations with these elements. This composite array of attributes can also be used for spirituality, as a similar system, minus the focus on mass action and behavior.

2. The Meaning of "Narrative" in Medical Fields

Above, it is mentioned briefly that attitudes critical of scientism have developed. Considering the matter more specifically, we note that the criticism of a view of life and a view of humanity based on reductionism and mechanism presupposed by modern medical care also presupposes a scientific standardization. We referred to the discussion of Mori, who described how a "pluralism of medical care" can incorporate complementary and alternative medicine (CAM), which can be considered to be on the rise, such as narrative-based medicine (NBM). We quoted his discussion at some length because it clearly states a point that we want to emphasize: medical care is a system that includes precarious and unpredictable elements, since the effects of medical care depend on the patient, even when treatments are performed identically in every case. Therefore, while medical care is very scientific, each incidence of treatment must be individually considered because the outcomes are not uniform. If "medical care" is considered only within the present field of biomedical research, we may overlook the limits of science and the uncertainty of scientific medical care as well. Each patient must be approached individually, even if he or she has many characteristics and symptoms common with other patients. Such thinking will make it impossible to say that the quality of future medical care will be the only index and ethical model that is indispensable for "client-centered medical care," the latter of which is sincerely concerned with all the characteristics of the person, including the flexibility of the mind. Moreover, "pluralism", a concept now integrated and used in the context of "medical care," considers matters of fairness and also prompts us to think of what is truly the best for each patient; this orientation toward fairness prompts us to respect the rights and autonomy of the patient without excluding all the possible alternatives, regardless of general medical care and CAM (Mori [2014: 9]).

In other words, evidence-based medicine

(EBM)—which represents the ideal of scientific medical care—aims at universalism, unlike CAM, which aims at being individual, but believes that there is one best option for each patient's medical care. As an overarching concept, pluralistic medical care is indispensable for client-centered medical care, requiring cases to be discussed on an individual level. Pluralistic medical care also influences NBM, too, in prompting us to reconsider a standard view of sickness, and to avoid forcing decisions on the patient. Our aim should be to communicate sincerely with each different patient through the narrative which he or she uniquely has. Moreover, a new meaning of patient illness (for the medical care provider) must be created.

Here, let us think more deeply about the role of religion in the field of medical care from the viewpoint of "the narrative" (i.e., the meaning of life and death). Traditional religion has played an important role in these matters. Anthropologist Clifford Geertz has defined religion as

"(1) a system of symbols (2) which acts to establish powerful, pervasive and long-lasting moods and motivations in men (3) by formulating conceptions of a general order of existence and (4) clothing these conceptions with such an aura of factuality that (5) the moods and motivations seem uniquely realistic." (Geertz [1987: 215])

Swinton's view of religion accords with Geertz; according to Swinton, religion is a formal system of belief that is maintained in a group comprising people who share a common perspective based on the nature of the world. This perspective is communicated through a narrative story, a habitude, a belief, and an agenda shared to create a specific world-view (That is, the narrative is a way of understanding human experience in the world, by jointly seeing and interpreting the world). Swinton suggests that the people who participate in a religion interpret the world by means of the structure of belief that organizes the religion as well as the data and the particular practices of that religion (Swinton [2012]).

The perspective of a religion on life and death influences the way a person and a community react to disease and illness. As such, religion becomes a powerful force shaping our understanding about diseases of the body. We do not experience disease in a vacuum; rather, our interpretation is formed by what we believe about disease and also on our supposition about how it should behave as well as what we think about the world. Swinton says that religion is a powerful "reduction board." When medical professionals do not acknowledge the presence of a religious view of a patient, they overlook something very important in informing how a patient copes with disease (Swinton [2012]).

Both Geertz and Swinton refer to modern societies prior to many of the advances in medical care. As a result, the efficacy of their analyses of the role played by religion in a modern society could be questioned, since they wrote before the rapid progress made in medicine since their time. Possibly, the fact that the causes of sickness are scientifically investigated and treatments are scientifically prescribed indicates that religion's role is decreasing. However, "remediless illnesses" still exist, and medical care based purely on science is not a universal experience. Given the enduring fact of human mortality, the religious dimension remains relevant, enabling many to face the inevitability of death.

Nevertheless, religion does not have the same influence that it had in former days. In the prescientific world, spirituality was the center of attention; this "[spirituality] is not religion but it is religious" (Fuller [2001]), and traditional religion has lost power through the progress of science and secularization, diminished to a supporting role. In the present situation, we expect that much of the spiritual care will not adhere to a specific religious tradition and that spiritual care will fulfill the role which religion had, to a greater extent, fulfilled in the past. However, confusion continues because of the inherent ambiguity of the definitions of such terms as 'spirituality' and ' the religious'.

One of the reasons why a non-denominational version of spiritual care offers some promise for patients derives from the "the limitation that religion contains. For example, Miyasaka, whose specialty is bioethics, shows one possible model for the role of religion in NBM. Analogy and paradigm, which are mainly discussed in narratology, can be discussed in the area of the science of religion, too, and may be applicable to medical care as well. Miyasaka introduces the use of analogy and paradigm. This science of religion refers not only to finding a similarity

between one's own tale and the analogous tale of a stranger, but in finding the tale of a stranger containing a specific element that becomes a paradigm.

Before an important decision in one's own life, a person makes his or her own tale by referring to a tale of a person whose narrative has become a model or ideal, thinking 'As that person narrates, so too will I.' For a Christian, the tale of a saint who is described in the Bible becomes an exemplary tale (Miyasaka [2005: 76]). Such a religious tale is meaningful for a patient committed to a Christian belief, in this case. However, using a specific religious tradition in caring for a patient who does not follow a specific religious tradition may lead to confusion on the part of the patient. As well, current mention of spirituality in a healthcare facility has no place in the clinical setting, aside from the traditionally designated "mission activity" of a cleric.

3. Spiritual Care and Narrative

Let us consider the relation between spiritual care and production of a narrative. A definition of spirituality as a working hypothesis has already been provided, which acts as a basis for us to define spiritual care as an activity that tells the patient something about the meaning of death and life established beforehand, without giving the patient the tenets of a specific religious system. From another perspective, "spiritual care" is care for "spiritual pain." Spiritual pain is the pain associated with the approach of death in addition to the pain of the body, i.e., the pain (caused by disease and associated with anxiety and loneliness) and social pain (such as the anxiety of the family and economic anxiety). Such pain is accompanied by questions such as "What meaning was there in my life?" and "Is there a meaning in living now as death approaches?" End of life situations also include feelings such as regret, reflection, and guilt, and contain a disputant as well (Miyajima [2012: 163]).

As for this spiritual care, Swinton describes its characteristics while depending on the two ways of knowing that are well known, nomothetic and ideographic. In other words, spirituality, too, is scalable and can be generalized on the one hand, and yet also has a personal side (Swinton [2013: 101-102]). The constant effect observed in patients who participate in religious practices, according to Swinton, is scalable and quantifiable in various ways. For example, extended average future lifetime, blood pressure, success rate in heart transplant, decrease in serum cholesterol level, decrease in pain during death, rate of heart stoppage, and some other factors are applicable. However, these effects come only from certain structural aspects of spirituality, such as specific elements of a religious practice, i.e., the community, the trained spiritual lifestyle requiring practice and healthy choices. On the other hand, Swinton introduces a descriptive spirituality of the personality. It is the ideographic spirituality as well. (Swinton [2013: 102-103]). Swinton thinks that spirituality has both narrative and compatibility.

Here, we must confirm beforehand concerning the effect on the narrative when switching from religion to spirituality. Susumu Shimazono, a researcher of religions, interprets spirituality as the individuation of religion. This individuative tendency and a narrative that pays attention to each one's tale are affinitive. (Shimazono [2007: 275-306]). In other words, Shimazono thinks that aiming at a narrative and striving for spirituality are parallel. This narrative is the (previously mentioned) traditional and fixed religious story that demands more of the individual who integrates spiritual care; however, the new meaning of invention that depends on such narrative may not have the same effect. Yuji Noguchi says, "The tale has the possibility to be transformed every time it is told and updated." This applies to spirituality more than to religion. Noguchi also says that sometimes the narrative becomes the one that is quite different, while another tale that has matched up so far in meeting in many ways "begins to change subtly and remains for a while." The tale or narrative has the possibility to change continually and has the possibility to be told once more, every time it is told, and to become quite another "tale." The change of "the tale" brings about a change of "the talk," which brings about a change of "the tale." Two meanings are contained, including "the talk," and the continuity of both is made "a tale" in the implication by the word "narrative," such that narrative and therapy aim at the change of "the talk," which is mutually continuous with "the tale."

Furthermore, Noguchi says as follows. It does not mean that the therapist knows the correct tale and the client is led to it. We do not know what kind of tale could be born. However, as a therapist and client advance their dialogue on an equal basis, a new tale is born, which is different from "the old tale involving problems". As well, a new "self as a tale" is born. (Noguchi [2005: 24-26]).

In striving for greater clarity relating to narrative and spiritual care in the healthcare setting, we find it important to discuss things according to both spirituality and religion. First, a therapist can serve as a religious counselor or chaplain. Then, if "the tale" or narrative is understood as a traditional and fixed religious tale, it is possible to say that the first half of the above-mentioned explanation is an explanation about the tale of the so-called "conversion." A religious awakening is one form of conversion. "The new self of the tale" mentioned here is a new religious self. Turning to the second half of the explanation, we suggest that it describes "the tale" in addition to the change of "the self" by the individual. If we look at the change of "the tale" or narrative, we can regard this change as a sort of creation of a new religion. In other words, a new tale and the tenets of a specific religious society are not forced on "the client"; rather, the client interprets the new tale for himself/herself. A "religion" in a narrow sense is not meant; the religious reference can be called spiritual, while also being religious. Thus, using a specific religious narrative does not contradict the above-mentioned ideal of "pluralism" in "medical care", as it can serve patients with various beliefs.

Yoko Yamada, a psychologist, describes such narratives as emerging from creativity, interactivity, and cooperativeness. Cooperation is supposed to occur in the individual, and the individual is supposed to engage in cooperation in interactions (mutual acts), though Yamada does not use the term "tale" but rather uses "mono-gatari", [物語 (literally, 'matter-narrative')] a unique expression for personal action. The mono-gatari produced by interaction is not a non-ego, and a subject is generated in cooperation among the people in the context of the tale (Yamada [2014: 16]). Therefore, Yamada, too, points out the expected relation between spiritual care and mono-gatari. Then, if spiritual care is seen from the viewpoint of cooperation, fostering the production of mono-gatari about the process of loss and fostering correction of the narrative through conversation, it is possible to enrich healthcare and even funerary settings (Yamada [2014: 175]).

4. New Possibility of Spiritual Care

There has been some debate about the meaning of joining narrative (the tale or mono-gatari) with spiritual care from viewpoints such as creativity, interaction, and cooperativeness. Itoh Takaaki is working on developing it further. Itoh calls the ideal way of spiritual care, as described above, "three-dimensional spiritual care" (Itoh [2014]). One-dimensional spiritual care would be a situation in which the care recipient is objectively recognized as the object of the care and the caregiver is believed to know the ideal way of correct caregiving and to transmit this care one-way to the patient. Key words such as rationality, analysis, and judgment apply to this dimension of care. Two-dimensional spiritual care would be a case in which both the caregiver and the care recipient follow the same religion, which would give them a basis for dialog such as a common spiritual horizon. Such a situation could be described by key words such as inter-subjectivity, empathy, and understanding. Three-dimensional spiritual care would represent the ideal method of care, as it occurs in contrast to and fusion with the horizons of the caregiver with the care recipient who stand on different parts of the horizon, to continue the metaphor. This three-dimensional spiritual care is described by key words such as creativity, awakening, and decision. That is, such a three-dimensional spiritual care creates an ideal in which the people involved richly experience the differences in each other, while being aware that they operate differently in terms of epistemology and are conscious of the effects on the participants. Not only the care recipient but also the caregiver can experience a new self-understanding or spiritual re-birth, through the use of the narrative story in the healthcare setting.

In the process of such care, individuals "begin to spin their own tales" "through the dialog in the relationship [which] is a neoteric spirituality expression" (Itoh [2014: 35]). The

possibility of spiritual care extends beyond the claim of Itoh with regard to playing an important role in the creativity of narrative, as discussed in the preceding section, concerning spiritual care. This extended possibility of spiritual care can help in gaining approval and in utilizing such a viewpoint. The next step is to think from the viewpoint of "cohesion."

5. Spiritual Care and Relationship

Creative spiritual care extends the possibility of a new relationship and the birth of solidarity. Shimazono says that when individuation progresses, there must be a self-help movement that produces the place of the solidarity containing spiritual awakening. Three examples are given: "terminal care," "self-help for addicted persons," and "meetings of parents of severely disabled children." Shimazono suggests that "cohesion" between "spirituality" and the "unpleasantness" of life can occur when a patient becomes aware of imminent death. Formerly, religion has often been the sole guide for spiritual matters, but a religious system develops into a form that requires a specific person, such as a priest, rabbi, minister, to be in charge of those about to die, utilizing subtle expressions, rather than appealing to a broader notion of spirituality as described in this article (Shimazono [2007]).

Nevertheless, when we focus on treatment of the terminally ill person as well as ideals such as cohesion (cooperativeness), our thoughts about family and others become more private, too. Indeed, with regard to "terminal care," Shimasono quotes the following from Kunio Yanagida: "The density is thick and the parent and child, the husband and brothers and sisters are partaking of life. There is therefore an affection for the heterogeneous pleasure, the sadness, the rage, and the hatred in the family. This affection is none other than the one which shows in a 'sharing' mental life" (Yanagida [1995: 200]). We should pay attention to the cohesion of the area that was held in common by such a family and an outside relative, too. The cohesion of the area described here is not the characteristic dense cohesion of a traditional village community. Needless to say, a spiritual narrative determines whether it is an activity described with words, and the words that are used to accomplish this are important. In a caregiving situation, certainly, the local words or regionalisms (i.e., the dialects) of each area are used, and so are the local meanings of certain words, meanings that are shared within linguistic cultural spheres such as the Touhoku (northeast) and Kansai (east). In such localities, cohesion in a wide sense can be realized, too.

Incidentally, in such a cohesion described above, it is common for a cohesion to be contained with another, what Miyajima calls "the transcendental being," (Miyajima [2012: 166-168]). Itoh, who considers three-dimensional spiritual care, states that, after the fusion of care-giver and care-receiver horizons have occurred between the care practicing person and the patient, this experience establishes the relation between the care practicing person and "the transcendental being" (Itoh [2014: 36]). Such a "cohesion" becomes apparent when discussing monotheism as well. For example, Toshiyuki Kubodera names the relation of the human being with the entities that cross the human being as "the vertical relation" with attention to spirituality; his explanation is as follows: "The being having to do with a Divine Mind, the mystic being, the being which crossed a human being, the being that does not change forever and the human being as the transcendental others means that it and he are concerned with and are living with the vertical relation" (Kubodera [2014: 23]). We call this intentional transcendental spirituality (or the transcendental intentionality of spirituality) (Miyajima [2012: 166-168]).

Let us suppose, however, as does Keiko Takagi, that there is no limit to such transcendental entities being designated as "God". One human being living in isolation nevertheless has a spiritual function. However, this function is not sensed and performed using only the five senses. Is it feelings that enable us to sense things that the eyes cannot see? And is it not both possible and plausible that internal feelings can be used to sense "the great one" who exceeds human intelligence and other things? These feelings seem to be very close to religious feelings. However, we must never conflate thinking with religious feelings and religiosity. By looking at the natural morning sun and the setting sun, is it not possible and plausible to call the feelings that all of us have something akin

to spirituality? Takagi describes this feeling and includes nature in "the transcendental being," as part of a list of things that can affect us in this way (Takagi [2014: 19]). Syuichi Kato, Michael Reich, and Robert Lifton name the craving that strives for something higher than the self by saying that "the view of life and death for the Japanese is symbolic non-thanatopsis"; they divide the category further into two elements: creativeness (through "work") and the natural empirical transcendence having to do with theology applied to biology (Kato et.al. [1977: 13-24]).

If it is possible to take a transcendental being widely in this way, undoubtedly, it is also possible to talk about religious matters without sticking to specific religious traditions. It should be possible, then, to call this spirituality. It will be possible to give "spirituality" a sufficient meaning in the field of caregiving and allow caregivers, confronted with such transcendental being, chances to utilize spiritual concepts and narratives, as they attempt 'to communicate' with patients.

6. Conclusion

In this article, we have defined spirituality is a religious phenomena which is not a particular religion itself. Some criticism of this perspective is to be expected. For example, it is unlikely that even care considered "spiritual but not religious" will be completely unrelated to the tenets of any specific religion (or religious tradition) or religious system. Religiosity does not spring fully-formed from nothing; rather, it emerges where the successful elements of traditional religions have been separated from their original contexts and changed. As well, traditional shrines can take on new meanings as so-called power spots, and some shrines are now attracting large numbers of worshippers and/or visitors. Nature worship, too, is filling such a role. It is reasonable to assume that all spirituality will have elements of established religion within it. In this article, we have pointed out that by joining narrative care with the narrative approach in spiritual care, spiritual care freed from any specific religious tradition can be utilized more creatively. We think that it is possible to produce a scene of creative care that joins spiritual care with the narrative approach, avoiding the imposition of a specific religion's tenets.

In addition, this article has discussed spiritual care mainly from a theoretical point of view. Therefore, analysis relating to the specific context of care during the terminal stage is insufficient. In the medical field, there are various problems such as medical announcements, coping with pain and suffering, and proper methods of communication. In response to such problems, for example, Takuya Okamoto (Okamoto [2015]), a doctor in charge of spiritual care, has written more practical knowledge for medical professionals. In addition, mental care at a particular healthcare facility was specifically described in a study by Yozo Taniyama (Taniyama [2016]), discussing spiritual care from the viewpoint of a religious staff-person who conducted a theoretical analysis of spiritual care. The relationship between the problem of concrete location of care as written in these papers and the theory of care discussed in this paper is a task still to be considered in depth.

As well, we can ask critically whether it is possible to call a dialog with the transcendental entity a "narrative." The subject of the narrative about communication with the transcendental entity which is not a living human being has not been extensively discussed in narrative theory to date, since narrative theory typically presupposes communication between two or more living persons. Therefore, our use of narrative theory in relation to spiritual care is thought to deviate from conventional discussion. However, such narrative talk with the transcendental entity occurs within a cohesive living person. If we take this type of "communication" into consideration, we can connect it with conventional narrative theory. This issue too will have to be explored further in future papers.

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