American Zen Hospital Chaplaincy: The Practice of Mindful Spiritual Care

Michael James Nilon
Gainesville, Florida

MDiv, Harvard Divinity School, 2010
B.A., University of Florida, 2001

A Dissertation presented to the Graduate Faculty
Of the University of Virginia in Candidacy for the Degree of
Doctor of Philosophy

Department of Religious Studies

University of Virginia
April, 2020

American Zen Hospital Chaplaincy: the Practice of Mindful Spiritual Care

Table of Contents

Introduction

Zen and Mindfulness in Spiritual Care

> The rituals of Soto Zen *are* its primary pedagogical method. Longs hours of meditation also teach one to present with suffering, without trying to escape it, or justify it, or "fix" it, or explain it away. This quality, which chaplains call "non-anxious presence," is what suffering people need: someone who can be with them compassionately in the midst of their suffering. The only way to be fully present with anyone else's suffering, without squirming, is to practice being present to one's own.
>
> —Wakoh Shannon Hickey, "Meditation is Not Enough"

Mindful of Another's Grief

I received a page around the middle of the day from a number I suspected was the Pediatric ED. Medical staff are some of the only professionals who still use pagers, and the obsolete devices never feel comfortable on my belt. After I reached the unit clerk for what did turn out to be the Pediatric ED, I learned quickly that an urgent situation was emerging involving a young mother whose child had died. I sat for a moment and collected myself by taking four deep breaths, and then I walked through the hallways to find my way to the Emergency Department, which has services for adults and children in units adjoined to each other. I walked with a deliberately quick pace, feeling the sensation of each footfall and feeling a mild sense of fear. As I used my badge to unlock the secure door of the unit, I caught sight of the young black mother and somehow her body posture communicated the live energy of a coiled up spring or a snake ready to unleash its potential energy into a kinetic expression. Her grief was hot and angry, the outpouring of all a mother's love in the voicing of a frustrated desire to protect her child. She was flanked on either side by a medical caregiver, a young white female doctor on her left and a young white female nurse on her right. As I came closer to her, I heard her sobbing and fuming.

Her tone was harsh and plaintive, and she kept asking one simple question over and over again, "Why, why did the EMTs drive so far? Why didn't they perform CPR on my daughter in route?" The young white doctor in a white coat, a mother herself I was to discover, looked at the patient with obvious discomfort, which at first I misinterpreted as a desire to be removed from the display of intense grief. Later I wondered if she felt responsible and maybe even guilty that she could not save the child's life. Her face wore a pained frown. She said over and over again, "We did everything we could. I am sorry, but we just couldn't save her." A white nurse in royal blue scrubs looked on, her face shining with empathic pain. For a moment, it looked as if the mother would spin into some kind of frenzy, and perhaps lash out, but then a young black as-

sociate care provider (ACPs are the staff who take care of the most menial caregiving tasks and report to the nurses) embraced the woman. She shook and sobbed, beating her fists against the ACP's back. I had neared the group of women by this time, and as the two women embraced I could see the anguish on the mother's face as she relaxed her anger for a moment and allowed herself to be comforted.

We found a room next to the trauma bay where the mother's daughter lay prone, and we took the mother into that room. I walked with the ACP and the nurse into the semi-dark room, and I noticed that we needed another chair. I went next door and fetched one and returned. The mother was again crying and again asking, "Why didn't they perform CPR on my daughter? Why? Why? Why?" The anguish in her tone was heartbreaking. No answer would satisfy her, because words fail to communicate what the heart needs in such a time as this. She slunk down in the chair, and as the nurse and ACP left the room, I found myself alone with her. I paid very close attention to my breath, regulating the steadiness of my breath in and my breath out. She continued to ask why, and then she slipped out of her chair and curled up in the fetal position on the floor. My body felt entirely uncomfortable sitting in the chair above her, so I sat next to her on the floor. She was facing away from me and silently sobbing, as we sat on the floor of the children's emergency room. Her right shoulder was pointing up in the air, and I placed the tips of the four fingers of my right hand on the point of her shoulder. My heart melted as her small tattooed arms quivered in pain. I cried very softly, and I felt a distant resonance of what it would be like to lose any of my three children to a premature death. After a few minutes she sat back up, and she continued to cry, but her eyes said that she was grateful that I sat with her.

Could I have attended to this bereft mother's pain without practicing mindfulness as a preparation for caregiving? Is mindfulness practice necessary for a chaplain to show compassion to the kind of patient in the kind of encounter I am describing? By no means! And yet mindfulness practice produced in me greater accuracy in reading the woman's emotional state, the emotional state of the caregivers, and my own emotional experience, and it made me more aware of options in choosing an appropriate response to these emotions without feeling overwhelmed by fear. It suggested to me that I must follow the mother onto the floor and that she needed physical comfort that would be gentle and appropriate, an understated touch of the fingers as she lie curled up on the floor. It drew my attention to how I felt in my body when I put myself in the mother's place. My heart would be inconsolable with the loss of one of my children, because my heart broke at the thought. Mindfulness is not a sudden cure for intensity of experience, but it makes intense experience useful (workable) because of the energy it makes available to the body once a chaplain learns how to dampen reactivity and make choices about how to respond. It makes the richness of a chaplain's intense experiences available for attuning to vulnerable others in way that shows these vulnerable others that the chaplain sees and cares for them. This way of learning

how to care through clinical experience is the hallmark of the moral practices involved in becoming a spiritual caregiver—learning how to be responsible for spiritual care—to which mindfulness can contribute in a meaningful way. Mindfulness can provide a chaplain with an apt tool that hones her sense, forged in dialogue and interactive self-narration, of who she is as a caregiver, the persons she shares her burden of care with and her relationships with them, and what they value together and uniquely. Mindfulness can be a tool for engaging in transparent interpersonal reflection on the moral equilibria that make up social practices of responsibility for giving care.[1]

***

This dissertation is an examination of how American Zen has entered into medical institutions through the embodied practices of Zen clinical chaplains and clinical chaplains inspired by Zen. It offers a nuanced analysis of two classes of practice in Zen clinical chaplaincy work, describing how Zen chaplains constitute an attuned and compassionate self through mindfulness meditation practice and how Zen chaplains constitute a responsible and caring self through clinical pastoral education. These two aspects of the self are not entirely distinct; rather they overlap and reinforce each other. Compassionate action taken in the service of patients and families reinforces the sense of responsibility that Zen chaplains have for caring for patients, families, and all sentient beings. My own personal experience and ethnographic exploration dovetail in what I write and discover here, because my thinking and feeling serve as a record of the passage Zen chaplains make when they cross over between the world of the retreat center and the world of hospital. This study seeks to follow these chaplains as they cross over from the locus of spiritual practices to the locus of medical care. My aim in articulating stories about this passage is to serve as a dialogical conduit between the world of the American Zen retreat center and the diverse medical contexts in which Zen spiritual practices are integrated into clinical routines to serve patients, families, and caregivers confronting the pain and suffering of illness and death. The novel element that causes a noticeable reorganization of clinical work is mindfulness practice, and mindful awareness, which changes the relationships between mind-body, self-other, and person-community.

In the study I have conducted, mindfulness meditation practices change the way that a Zen chaplain relates to her religious community, because mindfulness decomposes patterns of identity formation that sharply distinguish individual and communal processes of becoming. That is to

---

[1] I wrote these last few sentences in dialogue with Margaret Urban Walker's *Moral Understandings: A Feminist Study in Ethics* (New York and London: Routledge, 1998). See especially the section entitled, "Three Kinds of Narratives: Identity, Relationship, Value" (109-115) where she discusses how these three elements of moral reasoning take shape in interpersonal (social) interactions that involve "moral justification" and mutual and reciprocal moral accountability.

say that the mature and responsible Zen chaplain does not feel that she herself is entirely distinct or separable from the others for whom she cares. Her identity as a caregiver and the identity of others for whom she cares are interrelated and continuously shifting in affective, cognitive, perceptual, and energetic flows. In providing skillful care, she is responsive in her utilization of these various flows to connect with and spiritually support the patient, family, and caregivers she encounters. The primary means by which the Zen chaplain provides spiritual support is by using mindfulness practices to monitor and modulate her inner experience, noticing the energetic quality of that experience and making subtle changes to its hue and shape in order to stabilize herself and those to whom she gives care. She does this complex work of relating to herself in relating to others in order to live out the vow of the bodhisattva: to free all sentient beings from suffering and the roots of suffering. In my understanding, the only way to appreciate the significance of these changes in spiritual care introduced by Zen chaplains is historically and theoretically to contextualize the rise of Zen chaplaincy.

The Social History of Zen Chaplaincy

American Zen has had numerous powerful voices in the past half century, not the least of whom is Joan Halifax, who founded Upaya Institute and Zen Center (UZC). I look at her long career as innovator in American Zen spiritual and palliative care, and the effects the integration of Zen spiritual practices has had in healthcare. I trace the development of her style of teaching Zen spiritual and palliative care beginning with her ecological notions of the "extended self," her efforts to medicalize mindfulness as a complement to caregiving for persons at the end of life, and the acceleration of her medicalization of contemplative practices through a sustained dialogue with neurobiology. Halifax is responsible for assembling diverse resources for reinventing American Zen and using them to fashion an ecologized, medicalized, and neurobioligized *dharma*. She noticeably altered the shape of the socio-historical context in which she and her students have operated, so that she and her students have been able to thrive. As I studied Halifax and her school of chaplains, I concurrently completed clinical pastoral education, using my own experience of growth as a spiritual caregiver to resonate with the experience of caregivers I encountered and interviewed. I conducted person-centered ethnographic interviews to explore how the role of the Zen chaplain related to the life events of particular chaplains. Throughout my ethnographic and historical exploration of UZC, spiritual and ethical practices have stood out as the two most important units of analysis that make sense of Zen clinical chaplaincy.

Why begin this dissertation about Zen hospital chaplaincy by taking up an analysis of the practices constitutive of clinical chaplaincy? The actions that members of religious communities take show what the communities as a whole find valuable, which they communicate in explicit

and implicit ways. My particular ethnographic study of Zen chaplaincy in the United States since the early 1990s will focus on two classes of practice both of which manifest in the daily routines of Zen clinical chaplains in medical institutions. In the provision of care in clinical contexts, spiritual practices and moral practices converge in the ordinary routines of providing spiritual care. Spiritual practices permit Zen chaplains to constitute a self that is altruistic, empathic, authentic, respectful, engaged, and compassionate, while moral practices endow Zen chaplains with means by which to identify, engage in, and justify giving spiritual care to patients and families who experience pain, suffering, and loss. To look at these two classes of practices more closely, I will consider the narratives of various chaplains, including myself, who cultivate an ethical self and provide spiritual care. Before I explore these narratives in greater depth, I want to offer a sketch of the two domains of action where these classes of practice tend to unfurl, keeping in mind that these analytic distinctions do not always hold up in practice. That is, providing spiritual care can and does happen in the retreat setting, while meditation practices can and do happen in the clinical setting.

Consider a typical visit for a Zen chaplain in a clinical setting, paying special attention to its spiritual and moral valences. A Zen chaplain enters the hospital room of a patient who just had surgery to remove an intestinal blockage. The patient is in pain and her face scrunches up with agony. She is in hospital gown with a blue floral pattern, and she has the sheets pulled up to her face. The person who sits with her is made uncomfortable by the signs of misery she observes in the patient's posture. No words are spoken about the raw intensity of the searing, burning sensations where the patient's viscera have been cut apart to enable the doctor to save her by preventing a rupture or perforation of her bowel. The chaplain enters the room and asks to sit, receives permission, and fixes her steady gaze on the patient's face, feeling her own internal body mirror the patient's affective expression with a less intense resonance. The chaplain does nothing magical, she just stays with the sensation of pain and then sees what other emotional experiences come from that raw primary sensation. Maybe the chaplain feels fear come up in her own body, and then asks the patient if she is afraid. Maybe she asks the patient what the pain feels like. Can the patient locate it in the body? Does the pain or the loss of some part of herself evoke any other feelings? Perhaps few words will pass between the patient, family, and the Zen chaplain, who remains silent but tuned in to the patient's demeanor and posture. The Zen chaplain's work is simply to remain sturdy as she accepts the unpleasant emotions that one human being feels in the face of another's suffering. Her heart grows tender, and she wishes the patient no longer felt this intense debilitating pain. It is a simple and direct practice of bearing witness.

Compare a Zen chaplain visit with sitting meditation practice in a retreat center such as UZC, as the meditator sits in the Dokanji Zendo with its exposed Ponderosa pine pillars, statue of Manjushri, and painting of Green Tara on the Western Wall. Each time a Zen student of any type

comes into the room, UZC resident or guest or chaplaincy student, she bows to the Manjurshri (who is an embodiment of a Buddha) as he stands resolutely on the altar, prepared to cut away the illusion of self through the practice of wisdom (*prajna*), which Zen teaches will allow students to see things as they are. Visitors soon catch on to this practice of bowing to the Buddha, and more often than not they follow suit. The students choose to sit on various small cushions (*zafus*) situated on square padded mats (*zabutons*) facing inward toward the altar. After a few minutes of entering, finding a place, making hushed greetings, and enjoying soft chatter, quietly collecting one's self, the person responsible for inviting the bell to sing enters the zendo and calls the voice of the bell forth. Silently the Zen students sit, anchored to their breath, which means that they focus their attention on the breath as they sit quietly in a relaxed but erect posture, with their eyes halfway open. They breathe together as one community made up of numerous parts, as particular students concentrate their minds and bear witness to the sensations, images, feelings, and thoughts of memories, fantasies, and plans that arise and fall away in their consciousness. With an acceptance of themselves and an appreciation for the luminosity of their minds, this community of Zen students—including chaplain trainees—sits as the basic expression of their buddha nature.

These two paradigmatic moments of Zen chaplaincy reflect the collaborative and expressive nature of Zen approaches to spiritual care. These approaches are rooted in transparency, authenticity, and mutuality. The Zen chaplain comes to know her extended self in relationship to a wider community of sentient beings (*sangha*) that values egalitarianism and mutuality. The expression of who she is and her responsibility to these sentient beings emerges in the complex interaction of spiritual practice and caregiving. With small changes made to her practices of living with and caring for others across domains, the Zen chaplain embodies an ethic of responsible care for herself and the patients, families, and caregivers she encounters in the medical scene. The Zen chaplain moves her body-mind between these two domains of chaplain practice, crossing from religious community to clinical domain and vice versa. As she reflects on and dialogues about her responsibility to provide compassionate spiritual care with others in her communities (minimally a spiritual caregiving community and a religious community), she brings to bear the resources of her interior practices that cultivate the ability to be altruistic, empathic, respectful, authentic, engaged, and compassionate toward patients, families, other caregivers, and herself. Each of these groups of people that Zen chaplains serve have a differentiated stake in medical care, and the Zen chaplain does her best to balance between serving the needs of the differentiated parts of the whole system, even though she tends to prioritize the needs of the most vulnerable (patients and families) above all other stakeholders.

Zen Chaplaincy's Distinctive Practices

In part, paying close attention to the enactment of spiritual practices, especially sitting meditation practice, is a shift intrinsic to American Zen and therefore American Zen chaplaincy.[2] I will focus on American Zen hospital chaplaincy in particular, but Zen chaplains work in many socially differentiated secular institutions in the United States. As the dialogue between Japanese teachers and American disciples gained momentum in the 1960s, Zen Buddhist meditation practices became the central locus to represent and effect spiritual transformation. As Zen modernized in its transmission into the American social context in the last sixty years, meditation practice has served as the central practice that symbolized Zen in America, even though many other forms of practice inside Zen communities continued to have influence in shaping the life of the religious community. Part of the reason for this synecdoche of meditation is how transposable meditation practices have proven, finding their way into numerous forms of secular institutions since the 1970s. They require no formal commitment to any Zen Buddhist doctrine, yet they subtly incorporate Buddhist teachings on impermanence and no-self. Zen Buddhists, and other Buddhists besides, would say that this is because the *dharma* reflects the ontological structure of reality, and if one pays attention to mind-body-reality long enough, one will find out this truth without hearing the discourses of the awakened one (*buddha*). But sitting meditation is really only one form of practice, paradigmatic though it is, within a full array of practices associated with a Zen way of living life.

Like other Zen communities in the US, the form of Zen practiced at UZC involves a number of concentration and ethical practices besides sitting meditation (*zazen* or mindfulness) practice like taking the precepts (*jukai*), walking meditation (*kinhin*), and working meditation (*samu*). To talk about practices is to talk about ongoing action, including habitual actions one undertakes in a religious community in order to cultivate values by which one lives inside and outside of that community. As anthropologist Michael Lambek says, practice is the "relatively unmarked flow of action, including the habitual; it is action viewed or experienced as ongoing and, in effect, intransitive, the doing rather than the done."[3] Lambek distinguishes practice from performance, which involves explicitly marking temporal and spatial boundaries. A troupe of actors practice when they rehearse for a performance they may give on a few particular occasions. The practice of *zazen* entails sitting in a relaxed posture on a cushion with an erect spine and solid base and downcast half-open eyes, bringing one's awareness to the breath, gaining awareness of the mind

---

[2] David McMahan, *The Making of Buddhist Modernism* (Oxford, New York: Oxford University Press), 183-214.

[3] Michael Lambek, *The Ethical Condition: Essays On Action, Person, and Value* (Chicago: University of Chicago Press, 2015), 10.

when it becomes distracted, returning the mind to its attention on the breath, and so on, in an ongoing way over many years of repeated performance of the same type of act. The repeated practice of this type of act of returning one's awareness to the breath cultivates a deepening concentration of the mind, which is held in effect to stabilize and integrate mental processes. Zen teaches that meditation practices stabilize mental processes in such a way that the Zen student's mind functions in a different way even when they are not formally meditating. Zen students eventually translate the quality and stance of their concentrated mind from their sitting meditation practice into other dimensions of their home or work life.

I am concerned with this translation work between the relatively quiet scenes of retreat centers or zendos and the melee of daily life in medical institutions. So in this dissertation, I will look closely at how practices of calm and quiet reflection in the religious community create habits of mind-body that are transportable into domains of medical care, where threats of various kinds incite fear and foretell loss. Zen chaplains are responsible for embodying deep states of focus and openminded approaches toward experience, which they bring into caregiving practices. Because of UZC's combination of instruction in neurobiology with clinical chaplaincy, neurobiological discourse about concepts like "interoception" is one particularly powerful way of talking about how mindfulness meditation changes a chaplain's personal awareness of the body over time. Keiran Fox and colleagues describe "interoception" as "monitoring and consciousness of internal body states, such as respiration or heart rate."[4] Because they are instructed to make links between brain science and meditation, Zen Buddhist chaplains trained at UZC can justify the practice of mindfulness meditation on the basis of neurobiological concepts like "interoceptive awareness" spread through peer-reviewed journals like *Current Opinion in Neurobiology*.[5] American Zen chaplains and other clinical caregivers trained at UZC reimagine mindfulness in a new way that maintains continuities with the past and at the same time reinvents Zen tradition by interpreting bodily experience in light of the neuroscience mapping of consciousness. Images of the neuronal structures of the brain and extended nervous system allow scientists, doctors, and readers who specialize in or are curious about neuroscience to imagine how the brain works to create a sense of selfhood, which is in some sense fundamentally rooted in the mind's awareness

---

[4] Keiran Fox et al. "Review Article: Functional Neuroanatomy of Meditation: A Review and Meta-Analysis of 78 Functional Neuroimaging Investigations," *Neuroscience and Biobehavioral Reviews* 65 (2016), 221, http://dx.doi.org/10.1016/j.neubiorev.2016.03 .021.

[5] A. D. Craig, "Interoception: the Sense of the Physiological Condition of the Body," *Current Opinion in Neurobiology* 13 (2003), 500-505; Hugo Critchley et al., "Neural Systems Supporting Interoceptive Awareness," *Nature Neuroscience* 7 no. 2 (2004), 189-195; Antonio Damasio, "Feelings of Emotion and the Self," *Annual New York Academy of Sciences* 1001 (2003), 253-261; Fox et al., "Review Article: Functional Neuroanatomy of Meditation," 221; for a practical application of this knowledge, see Fleet Maull, *Radical Responsibility: How to Move Beyond Blame, Fearlessly Live Your Highest Purpose, and Become an Unstoppable Force for Good* (Boulder: Sounds True, 2019), 203.

of the body. In neuroscientist and philosopher of consciousness Antonio Damasio's reasoning, "the key to the self is representation of the continuity of the organism" furnished by "interoception," which markedly contrasts with the variability of external percepts.[6]

Speaking in a neurobiological idiom gives mindful chaplains persuasive language that they can use to justify their clinical practices in dialogues with collaborative partners in biomedical settings. Chaplains can interpret themselves as responsible parties who invest in technologies that they would say enhance their caregiving abilities through this body of empirical knowledge. In an effort to shore up their own roles in the hospital system, expanding their jurisdiction beyond end-of-life situations, clinical chaplains have sought to justify their ongoing presence through scientific discourses that legitimize their practice.[7] They may speak of grief work or spiritual distress or the analysis of family systems. Bereavement and systems theory have proved influential in the biomedical sphere, but the newly ascendent discourses of neurobiology are somehow different. They are different because they provide detailed maps of the changes to organic systems that take place on account of shifts in habits. These changes in organic structures come to pass as the outcome of new regimes of practice. So practices become the central analytical concept in studying the implicit systems that live in the body and organize certain modes of corporeal life. As an outcome of the training they receive at UZC, scaffolded in rational scientific (medical or neurobiological) explanations of this training, clinical chaplains incorporate mindfulness practices that condition their bodies to act with empathy and compassion. The Zen chaplain who practices mindfulness mediation learns how to pay attention to and care for her interior world, and this gives her the power to attend to and accept the interior world of another. This is not a process of caring that occurs as a matter of course; it is rather negotiated, contested, and partial. When a chaplain provides spiritual care, it requires discipline and struggle to transform empathy into mature compassionate care.

This is why the study of clinical chaplaincy that begins with practice sheds useful light on the emergence of Zen spiritual care, and how Zen spiritual care is in tension with spiritual caregiving that preceded Zen. Along these lines, historian of religion David Hall provides two rationales for studying religious practice. First, the study of practices "encompasses tensions, the ongoing struggle of definition, which are constituted within every religious tradition and that are always present in how people choose to act."[8] Indeed, I would say in a slight deviation from Hall's framing, choosing to act is in fact an outcome of religious or spiritual practices that make choice pos-

---

[6] Damasio, "Feelings of Emotion," 254.

[7] Wendy Cadge, *Paging God: Religion in the Halls of* Medicine (Chicago: University of Chicago Press, 2012), 171-190.

[8] David D. Hall, "Introduction," in *Lived Religion in America: Toward a History of Practice* (Princeton: Princeton University Press, 1997), xi.

sible in the context of a differentiated social sphere. Practices govern behavior even in environments when conditions prevent ongoing rational deliberation about which of various options best fits a person's aims. Social practices of a certain variety make social actors aware they have choices and empower them to make them as an obligatory expression of freedom and autonomy.

Second, "practice always bears the marks of both regulation and what, for want of a better word, we may term resistance."[9] Besides regulating community life, practices regulate the interior bodily substrates and neurological systems that relate to them. But practices do more than regulate behavior or affect. They do more than express the dominant implicit knowledges of culture. Practices embody a variety of competing and contrary logics, some of which find their way to expression outside of any plan whatsoever, because what bodies do can be spontaneous, creative, or kind without any plan governing them at all. The logics of embodied practice permit the presence of resistance, or any other tangential if not oppositional force in a complex field, to live on inside of daily life. Zen alters clinical chaplaincy by establishing parallel work of embodying a spiritual presence (not altogether different from Christian or Jewish practices of embodying a spiritual presence) that does not resist Christian embodiments of spiritual presence but is differently constituted. These ways to be spiritually present constitute, institute, and reinforce forms of self- and co-regulation. And spiritual presences are in some ways ungoverned, and perhaps ungovernable, dimensions of action in which mysterious forces are at play.

Interior and Exterior Practices of Spiritual Care

The relay between retreat center or zendo and clinical setting reveals the work of embodiment, because it is the bodies of caregivers that carry mindfulness practices across boundaries between religious and medical institutions. I examine how the practices that shape particular religious communities cross boundaries into the world of secular institutions and the interlinking of differentiated social spheres through rationalized discourses about medicalized mindfulness practices. My intention is to draw into analytical discourse how the bodies of American Zen clinical chaplains, and their implicit knowledges, carry spiritual practices and moral practices within corporeal schema.[10] The bodies and corporeal schema of Zen chaplains cross over into medical contexts, informing the logics and practices of medical care that they find. The bodies of clinical

---

[9] Ibid.

[10] See William Hanks, *Language and Communicative Practices* (Boulder: Westview Press, 1996), 135-138. He analyzes three features of Merleau-Ponty's of corporeal schema: 1) the actor's posture/motion; 2) the actor's awareness of the relationship between body and its intersubjective field; and 3) the actor's intuitive (pre-reflexive) grasp of the infinite possibilities for posture in relation to the topographical array of a field.

chaplains bring "new somatic modes of attention," new "knowledge of the body," into contexts in which clinical caregivers are composing a community of compassionate care.[11] Understanding how corporeal schema relate to spiritual practices illuminates the two processes of Zen chaplain maturation: 1) they engage in new ways of "dwelling" within their embodied minds, and 2) they engage in new ways of "crossing" as they translate practices between institutional domains.[12] As Thomas Tweed describes it, "dwelling" calls to mind the various activities by which persons emplace themselves in the world. These forms of action deceptively seem either passive or static in many instances, but in truth "finding a space and making a place involves a great deal of activity."[13] Spiritual practices, as ways of dwelling, express the logics of embodiment that constellate persons in communities; they interlink self and other in mutually attuned relationships. Frames of reference focusing on self or focusing on others "that emerge from these processes and practices" of dwelling "allow the religious to map, construct, and inhabit ever-widening spaces: the body, the home, the homeland, the cosmos."[14] They can make processes of interior change visible, articulable, describable. At UZC, chaplains learn to discover the unique capacities of corporeal schema through mindfulness, which constructs the body-mind as an instrument attuned to its own internal frequencies of coherence or dissonance in relationship to the world.

"Crossing," on the other hand, enlivens the interaction between persons and institutions through the multiplication of contacts and potentials for integration. In Tweed's language, religions "are not only about being in place" or placemaking, "but also about moving across." In the idiom of crossing, religions "employ tropes, artifacts, rituals, codes, and institutions to mark boundaries, and they prescribe and proscribe different kinds of movements across boundaries."[15] Processes of transmitting, translating, and transcending enact the crossing of boundaries between nations, social institutions, communities, and persons. Japanese Zen teachers coming from monastic settings transmitted their knowledge to American Zen communities comprised of laypersons. American Zen teachers have translated the *dharma* into forms of practice exportable into secular institutions and interfaith dialogues. In the process, American Zen *dharma* has been medicalized, militarized, therapized, etc. As the American Zen clinical chaplains I interviewed told stories of crossing over from communities of religious practice into medical domains, many

---

[11] Thomas Csordas, "Somatic Modes of Attention," *Cultural Anthropology* 8 no. 2 (1993): 135-156; Michael Jackson, "Knowledge of the Body," *Man* 18 no. 2 (1983), 327-34.

[12] See Thomas Tweed, *Crossing and Dwelling: A Theory of Religion* (Cambridge: Harvard University Press, 2006), where he theorizes both "dwelling" (80-122) and "crossing" (123-163) in a way that takes into account humanistic and neurobiological frames of reference.

[13] Ibid., 83.

[14] Ibid., 84.

[15] Ibid., 123.

narrated how they took advantage of the features of embodied consciousness—corporeal schema—to change institutions involved in the art of medical practice. This begins with the incorporation of meditation practices into clinical spiritual care, which then exerts a subtle influence on medical care more broadly. As a form of crossing, medicalizing discourses allow the mindful chaplains trained at UZC to explain the connection between meditation practices and cultivated character traits like interoceptive awareness with greater neurobiological specificity, nuance, and persuasiveness. They justify their use of meditation practices by showing how cultivating them is a responsible manner in which to cultivate engender caregiver dispositions of empathy, altruism, and compassion by referring to credible proofs provided by brain science.

The beginning point of American Zen approaches to spiritual care in medicine is a robust respect for the naturalness of death, which takes death as inherently truth-telling. Pain, suffering, illness, aging, and death are the universal spiritual solvent that dissolves all illusions of permanence across all space and time. UZC communicates a universalizing message that will make stalwart relativists shudder. This commitment to learning from death how to be more responsible in her care for others and more authentic in the expression of her deepest self frames the daily round for Zen chaplains training at UZC. At UZC, the day begins with sitting meditation and the day ends with the night chant, a meditation on the mortality of human beings. Zen chaplains initiate spiritual practice from the recognition of the limits of human power, at the border of human knowing—"where questions mount and answers fail."[16] These places of "limit situations are culturally mediated moments—or time spaces—when selves approach the threshold of the humanly possible and face the limitations of embodied existence."[17] Zen Buddhist chaplains in the retreat setting bring themselves at least twice daily in formal meditative practice to the limits of their knowing. They stabilize the mind through a process of observing and letting go of sensing, perceiving, imagining, feeling, and thinking. They bear witness to human mortality in their daily living, transporting the Zen orientation to finitude from the *zendo* to the clinic. They explore their own looming death experientially and not merely as an object of intellectual knowledge. They find impermanence and death in their exhale, since dwelling in the human body also means living towards the inevitable moment of dying. They translate their way of sitting with death into the medical institutions in which they work in order to humanize dying.

Practices of "dwelling"—building and tinkering with the body as the house of the mind—and "crossing"—importing practices that reorient the mind between institutional domains—have great potential to reinvent spiritual caregiving in medical domains. This is the most striking power of the values that spiritual practices communicate and inculcate in human beings: they orient

---

[16] Ibid., 136.

[17] Ibid., 137.

action toward a horizon of ultimate meaningfulness.[18] Thus Charles Long writes in *Significations*, "religion will mean orientation — orientation in the ultimate sense, that is, how one comes to terms with the ultimate significance of one's place in the world."[19] When a Zen chaplain finds her ultimate orientation, this process of value clarification requires her to attempt to enact what she ultimately values. She directs her actions in such a way that she can respond to and embody what she senses and confirms in dialogue is a "strong evaluation."[20] It is only at moments when the vicissitudes of life strip away all other concerns that strong evaluations come into sharper focus as elements of experience that transcend the self, and for them to concretize they must enter into the dialogical ways agents determine their responsibility in community with other responsible selves. These dialogical "moral decisions emerge as aspects of unfolding narratives," as anthropologist Cheryl Mattingly says, that orient and reorient the narratives and the moral agents who articulate them mid course.[21] The "moral agency" charted by these narratives is a "painstaking process," a journey made by persons in community engaged in processes and projects of "moral becoming," seeking desired and desirable values that transcend them.[22] Along these lines Hans Joas writes: "strong evaluations are not only desired but desirable," because these values "seem to originate outside the person's subjectivity."[23] Religious and spiritual values—as strong evaluations—have gripping power, in an affective sense that comes from outside the person who feels them and reshapes her values in light of them, thereby reorienting actions from the outside inward. The reorientations of caregiver values appear in the narratives of becoming that moral agents tell in community. In an inverse movement (from the inside outward), the interactive expression of strong evaluations between Zen chaplains draws multiple agents into an "expressive-collaborative" ethical community that assigns, justifies, explains, and reasons

---

[18] Charles Long, *Significations: Signs, Symbols and Images in the Interpretation of Religions* (London: Davies Group Publishers, 1999), 7; likewise the ultimacy of strong evaluations defines the shared horizons of significance that frame the narration of self-articulating subjects in Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge: Harvard University Press, 1989), 4, 14, 20, 42, 122, 332, 333, 337, 383.

[19] Long, *Significations*, 7.

[20] Hans Joas, *The Genesis of Values* (Chicago: University of Chicago Press, 2000); Charles Taylor, *Sources of the Self*.

[21] Cheryl Mattingly, *Moral Laboratories: Family Peril and the Struggle for a Good Life* (Berkeley: University of California Press, 2014), 83.

[22] Ibid., 82-83

[23] Joas, *Genesis of Values*, 130.

about spiritual care on the basis of internal affective sources, and speech about them, shared with others.[24]

Interpretation of how strong evaluations motivate Zen chaplains requires the close analysis of spiritual practices and moral practices that displays the logic Zen chaplaincy. The logic of interpreting practice by translating them from retreat centers to medical contexts follow this simple but powerful sequence of analysis: "if logics are embedded in practices, articulating them demands we go out into the world and immerse ourselves in these practices."[25] This is to say, in order to recognize the logics that govern the actions comprising social life, one needs to consider the repeated actions that form patterns of habit, which issue silently from, remember, and alter corporeal schema. This means dissecting what sociologist Courtney Bender describes as the reinterpretative efforts of actors who cross disparate social contexts.

> Practices, we know, do not merely reproduce social structures. Since they are embodied in actors who live in particular social settings and who use those practices to build unique perspectives in the world, they are always subject to creative change and reinterpretation. Individuals both reproduce structures and change them.[26]

The adaptation of novel spiritual practices to medical institutions is at the heart of social change that Zen chaplaincy introduces into medicine. This is because mindfulness meditation practices generate a set of embodied dispositions and harmonize them across bodies, and these dispositions then provide the means by which persons and personal experiences regenerate and alter social structures.[27] These spiritual practices based in mindful awareness circumscribe agency. They show the limits of and orient personal choice, making one perceive choice as a field of options in which one defines oneself through the particular array of options that one selects.

Just as important as showing how personal choices and dispositions are limited by practices and how practices regenerate social institutions, subscribing to Bender's view can open up an

---

[24] For a description of the "expressive-collaborative model of morality," see Margaret Urban Walker, *Moral Understandings*, 59-70; the expressive-collaborative construction of "shared horizons of intelligibility" through the dialogical interactions of self-narrating subjects as a moral phenomenon is also crucial to Charles Taylor, *Ethics of Authenticity* (Cambridge: Harvard University Press, 1991), 35-37.

[25] Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (London: Routledge, 2008), 10.

[26] Courtney Bender, *Heaven's Kitchen: Living Religion at God's Love We Deliver* (Chicago: University of Chicago Press, 2003), 6. See also her *The New Metaphysicals: Spirituality and the American Religious Imagination* (Chicago: University of Chicago Press, 2010), 2-5.

[27] See Pierre Bourdieu *Outline of a Theory of Practice*, trans. Richard Nice. (Cambridge: Cambridge University Press, 1977), 76-80 for a theoretical expression of how practices embody and reproduce social structures in the personal experience of group members. Bender is altering that understanding of Bourdieu's that practice reinforce or perpetuate social structures by highlighting how practices have a quality of emergent creativity.

appreciation for how practices encoded in the body and extended nervous system provide the iterative mechanism by which to alter, and not just maintain or reinforce, social structures and institutional logics. That is, just as much as they reinforce social structures and character traits, practices alter social structures and character traits.[28] This is essential to my argument, because I will advance a series of claims about the reinterpretation of practices across institutions that explore how the bodies of chaplains and caregivers import logics through practices that are significantly altering medical care. What Bender calls 'reinterpretation' I am choosing to call 'translation' and I see the process of translating spiritual practices from UZC to clinical institutions as essential to institutional change in the art of medicine. Practical changes produce the beneficial result of remaking communities in adjusted, altered, or, as Annemarie Mol describes them, 'doctored' forms. In the medical context, "caring is a question of 'doctoring': of tinkering with bodies, technologies, and knowledge—and with people too."[29] In conjointly translating practices, caregivers and patients tinker with care in order to improve it. This means that translating mindfulness meditation practices into caregiving is 'doctoring' in Mol's sense. When a chaplain doctors care, she is responding to the patient's need to put the breaks on "runaway extensions of instrumental reason" in routinized medical care through recourse to human interactions "enflamed by an ethic of caring."[30] These practical changes aim to improve care based on explicit caregiver and patient conceptions of what is good, whole, integrated, and well. Among other things, caregiver practices doctor various modes of embodied awareness—corporeal schema—at play in medical care.

The Plan of the Dissertation

Any generative insights this dissertation produces depend on my own training in and perspectives on clinical chaplaincy and clinical pastoral education, and I come to this training with a theological commitment to liberal Protestantism and an insatiable curiosity about American Zen. I am what historian of religions David McMahan would call a "Western Buddhist

---

[28] The perspective that meditative practices alter human capacities forms the basic argument of Daniel Goleman and Richard Davidson in *Altered Traits: Science Reveals How Meditation Changes Your Mind, Brain, and Body* (New York: Penguin, 2018), which is interwoven with their interpretation of the current state of knowledge in contemplative neurobiology as of the time they composed their book. The core units of analysis for analyzing the change of character traits in their perspective are the mind, brain (extended nervous system), and body, though they do not deny the importance of human communities in the development of human character traits through meditation practices. Indeed, both authors have participated in Theravada and Theravada-inspired insight meditation communities in the United States and abroad.

[29] Mol, *Logic of Care*, 14; see also Taylor, *Ethics of Authenticity*, 106.

[30] Mol, 14.

Sympathizer."[31] In order to show how my experience serves as the conduit through which the narratives of the chaplains can be meaningfully interpreted, in the first chapter I provide a description of the hospital system where I have learned to practice the arts of contemplative spiritual care. This is the community in which I have become a multivalent self responsible for care, in relationships with other caregivers, defining myself through processes of dialogue and mutual and reciprocal self-narration.[32] To provide a basis for understanding the changes chaplains inspired by American Zen introduce, I describe Baptist Health (BH) and its clinical routines, the clinical pastoral education program at BH, and the assumptions about the articulation of pastoral identity in storytelling forms and the responsibility for giving care as a moral practice that involves expressive and collaborative community interactions. Clinical chaplains recognize themselves as caregivers and tease out their own personal and theological limitations and unique giftedness by engaging in several forms of self-expressive documentation. The documentary process opens each member of a chaplaincy cohort to the feedback of their cohort and supervisor, creating a rich and interactive form of community learning that identifies patterns of grief and family system dynamics as formative elements in the personal pastoral style of a chaplain. My own personal experience in clinical pastoral education during my residency has been inflected by my ongoing engagement in the study and practice of Zen, which has changed my views about my own spiritual path though I remain a Protestant.

Halifax's rise occurred in a social and historical context rich in terms of resources for the development of spiritual practices, and her insight and creativity have depended on her having access to ideologies of personhood and practices of self-cultivation as she matured into the leader of a spiritual community. In the second chapter, I tease out some of the most important historical antecedents of Halifax's style of American Zen. It helps to have a clear understanding of at least three historical trends in the dispersal of religious values, ideas, and practices that defined the historical context of the United States in the first half of the twentieth century. The background ideology that so dramatically shaped conceptions of the person was Romanticism, which gave rise to a sense of the healthy person as integrated, self-expressive, and authentic. American Zen Expressivism, which characterizes Halifax's corpus, frames this sense of the awakened Zen chaplain as someone who is engaged in the expression of her own hidden depths. The Romantic sense of the self combined with Zen approaches to the spiritual path as spiritual seekers engaged in the practice of Zen after they learned about Zen ideas through the religious reading practices that were the common property of communities of religious liberals that dominated United States society and formed church-state partnerships from the 1890s to the 1950s. Though Halifax is

---

[31] McMahan, *Making of Buddhist Modernism*, 28-30.

[32] See again Walker, *Moral Understandings*, 109-115.

very much a product of her era and emerged out of the time in which liberal religion was a dominant force in the United States, she is also a skillful and creative teacher who reinvents American Zen traditions in her own style.

The third chapter narrates the rise of UZC in chaplaincy training within the context of Halifax's reinvention of American Zen. My personal study and practice of Zen began in earnest at Harvard Divinity School in 2008 when I took a course entitled "Buddhist Peacemaking Ministry" with Bernie Glassman, though I was exposed to Thich Nhat Hanh a decade before through discussions with a mentor in the United Methodist Church. It is not an uncommon pattern for a liberal Protestant to read about Zen and engage with a popular modern Buddhist author like Nhat Hanh as I did. I learned in greater detail from studying the life and work of Glassman, Halifax, and others that this pattern is fairly widespread. While the pattern of first being exposed to Zen ideas through reading followed by a deepening engagement with Zen through meditation practice holds as a commonality across the narratives of most exemplars of convert Buddhism, each exemplar shows distinctive patterns. In the case of Halifax, her style of American Zen has unfolded in three distinct phases: 1) she ecologized the practice of Zen chaplaincy; 2) she medicalized mindfulness in order to frame a Zen practice of being with dying; and 3) she has accelerated the medicalization of mindfulness by mapping the interior spaces of self-transformation through a sustained dialogue with neurobiology. These three steps in Halifax's personal development arm the Zen chaplains she trains with a late modern *dharma* that is scientifically oriented, biomedical defensible, and responsive to the needs and moral distresses of the medical context.

My interest in American Zen chaplaincy does not end with Halifax but really only just begins there. In the subsequent chapters, I trace out how her teaching affects social institutions more broadly, especially medical institutions in the United States as the neurobiological scientific revolution sweeps across medical systems. The final two chapters of this dissertation trace how radical changes in caregiving are underway through altered means of the self-constitution of clinical chaplains that are grounded in mindfulness and American Zen practices based in mindful awareness and open monitoring techniques. These practices are predicated on paying close attention to the sensational, perceptual, cognitive, and affective content of experience in a non-evaluative stance. Zen chaplains, meditation teachers, Zen-inspired philosophers and social scientists, and contemplative and affective neuroscientists are working together to map how these practices lead to demonstrable changes on the part of those who engage in them regularly in terms of: 1) the structures of the extended nervous system; and 2) character traits. UZC is a key player in bringing together the collaborators of the various social groups I name above, and the chaplains who train at UZC learn to identify, interpret, and justify chaplaincy practice in terms of neurobiological warrants for and explanations of empathic and compassionate care.

In the fourth chapter, I describe how particular chaplains work with their experiences of grief in order to facilitate spiritual maturation in themselves and others. As chaplains face the challenges of loss, hardship, and sorrow, they grow more mature and therefore more capable of feeling and enacting empathy and compassion for themselves and others. Mindfulness practices are integral to this work, and Zen chaplains claim that this is demonstrably the case in ways that can be proven through both subjective accounts and neurobiological study. I look closely at the practices of mindful spiritual care, and how this is interpreted through a medicalized lens.

The fifth chapter narrates the compassionate actions of Zen chaplains trained at UZC in diverse medical contexts. I consider how these chaplains improvise compassionate care in clinical settings from the basis of internalized contemplative modalities like Halifax's GRACE mode. After completing a year of interior work—inner chaplaincy—UZC's chaplains undertake an integration of their new pastoral identity into the medical institutions in which they work. In transitioning from the retreat center to the medical context, they translate modes of embodied empathic and compassionate caregiving into institutions governed by biomedical norms, relying on neuroscience warrants to shore up their justifications for giving care in the ways that they do.

In the sixth chapter, I engage in a robust discussion of the changes in medical institutions afoot at the University of Virginia Health System (UVHS) as a result of the collaboration between UZC, Joan Halifax, and several leaders in the School of Nursing at the University of Virginia. I document how this work of introducing mindfulness and other Asian contemplative resources into the medical scene involved partnerships between UZC, UVHS, the school of nursing, the Compassionate Care Initiative (CCI), and clinical chaplains at the University of Virginia. I show parallels between these changes and the incorporation of mindfulness into similar institutions in which Zen chaplains work after completing UZC's chaplaincy training, some of which meet with disinterestedness on the part of other staff. I address the specifics of mind-body practices and the physical instantiations of American Zen beliefs that chaplains learn and practice at UZC and then bring into their clinical work. My study finishes with a consideration of my own experiences of providing care in a clinical setting where Protestantism still has a leading role, which is reflected in the mission statement of BH. The mission statement frames the hospital's purpose in terms of providing compassionate and dignified care following the example of Christ. Yet, even when Christ is explicitly named, Zen practices can still play an important role as a means by which to change patterns of mind-body integration through mindfulness practices that frame human experience as richly textured, fragile, and compassionate.

Chapter 1

The Field of Clinical Chaplaincy

> Initially, others teach us to take responsibility for ourselves as bearers of particular identities and actors in various relationships that are defined by certain values. Later some people are in positions to demand that we do so, and some of us are in positions to demand it of some of them. So this system provides us with a medium for expressing our identities, relationships, and values through our senses of responsibility, and it requires of us that we do so.
>
> Margaret Urban Walker, *Moral Understandings*

A Family Meeting on the ICU

We sat in seven chairs in the small alcove where families often meet before or after visiting patients on Baptist Medical Center South's Intensive Care Unit (ICU). Baptist Medical Center South, or just South as the hospital is sometimes called, is nestled in an affluent neighborhood on the south side of Jacksonville, FL. Seven nearly floor-to-ceiling windows arranged in the shape of an L permitted natural light to pour into the room accented with blue, green, and beige tones in the paint and flooring. The cool and soothing colors of the alcove resembled the pattern of colors and artwork for the entire unit. The spotless polished floor tiles communicated antiseptic hygiene. The pattern alternated green, blue, tan, and light ochre with slate grey tiles that looked the same color as river stones. Hand sanitization foam and signs with reminders to "foam in and foam out" invited caregiver compliance with hand hygiene protocols at every doorway. Tasteful landscapes of beach and estuary scenes appealed to the sense of peace, order, and the natural flow of life. They evoked the message that the natural and organic course of life is like a river inexorably flowing to the sea: the sacred journey of something as ordinary as death. The images and routines of the unit suggest this theme, but never name it explicitly. It is the water in which we as caregivers swim.

Peter's parents and aunt sat on one side of the alcove with two nurses and the attending physician sitting on the other side, and I sat in-between both groups. I had just started my chaplaincy residency two months earlier, and felt anxious as I sat down before the meeting started and looked out through the glass of the window at the bright blue October sky. Next to me on my left sat the physician, a pulmonologist by training, who was known to be a little emotionally withdrawn and self-identified as non-religious. He had difficultly relating to the family's fervent, evangelical faith. Peter's mother Jennifer had lost her mother in a shocking event that involved a week-long stay on the ICU before she was downgraded and suddenly died because of unantici-

pated heart failure. She bristled with anger and energetic protectiveness of her son. Peter's father William had a calmer disposition, but shared in his wife's staunchly outspoken and faithful presence. William slept on the teal couch with its vine and leaf pattern next to his son each night, and Jennifer kept vigil during the day. They looked haggard, with deep hollowed-out eyes.

On the eastern wall, an estuary scene of the Northeast Passage of the St. Johns River, painted in acrylics by a local artist, depicted a watercourse from behind a crested hill. The artist captured the wispy beach grasses in impressionistic aqua, sea green, and sky blue brushstrokes. It spoke of the calm of deep flowing waters. Directly behind Jennifer, the landscape stood in sharp contrast to the firm and politely angry face of Peter's parents. With his beaded bracelet that reminded me of a rosary and his coiled posture, the pulmonologist sat with a still poker face and maintained a practiced stance of receptivity as he responded to the parents' concerns. Fear was palpable. Peter, still in his early twenties, had been vaping prior to the onset of sudden respiratory distress, and the parents believed that the oils used in the vaporizing solutions could be the cause of their son's condition. They had an article in hand that they had found online, which suggested treatment with steroids, but the pulmonologist was resistant to this idea, because it had little empirical evidence behind it. No randomized controlled study had effectively demonstrated that treating acute respiratory distress syndrome (ARDS) secondary to vaporizer use with steroids cured the disease. I knew from side conversations in the room with Jennifer that she felt that more aggressive treatment of her son's condition with steroids would be the best course of action. The attending physician wanted to try to run more diagnostic tests to determine the origin of Peter's high fever, even though blood cultures over the past week revealed no identifiable source of infection.

We sat in the alcove, a middle ground of sorts in the spaces of the unit, with the doctor cooly and logically explaining the plan of care, subtly bristling when Jennifer insinuated that the medical team did not have a viable course of action. Her eyes flashed with anger, but she remained cordial as she challenged him by saying it didn't seem the medical team had a strong option, showing the courage of a mother fighting for her child's wellbeing in a medical domain that placed great value in the authority of a doctor's knowledge and in empirical evidence. "We do have a plan," the doctor said in defense of the unit's methods, "we have a way to heal your son that is tested and true." He was cool, understated, and irritated about the interference. I could feel the fear and uncertainty of Peter's parents and their desire to protect him. I could feel their desire to control the care he was given. I could also feel the weight of the knowledge and power on the side of the medical team. They felt confidence in their way of going about healing Peter. They felt like they knew what was best for him, and they had evidence and experience on their side. I sat in the middle and listened intently to the content of the disagreement and for the affective undercurrents. It was exquisitely tense, and I felt an inner sense of unease and agitation. In each

person, it seemed to me that I could feel fear. What if our son dies? What if our methods don't work in this case? The energy of that collective fear led to a quickening of my senses.

After the discussion drew to a close and the doctor won a hard-fought acquiescence, the mother asked if we could pray for the doctor. The doctor balked, in a non-plussed tone, he said, "but I don't believe in God." He seemed to be saying, I'm very good on my own two legs thank you. I intervened and said very simply, "They want to ask for God's blessing on you and your work." And the doctor without protesting one word more accepted the prayer he didn't believe was effective with a forlorn look at me. It was Jennifer who prayed, "God, please give this doctor clarity of mind to see the true problem that is afflicting my son, and provide him with the caring touch to heal it." The believers said, "Amen!" I was among them. Less than a week later, Peter regained consciousness, and a day after that the attending physician (by then another doctor) downgraded him to another unit. His mother grumbled almost every day about the way his care unfolded, while we prayed together for her son after each round of complaining.

Much of chaplaincy unfolds in the context of hospital units (the ICU is a particularly dramatic version of the scene), where art, medical routines, clinical caregivers, and spiritual caregivers urge patients and families to surrender to the natural flow. (Yet caregivers work hard to support even the most stubborn of patients and families as best they can.) The artistic renderings of beaches, water lilies, and Mexican Daisies in various styles (impressionist, abstract, or realist) encourage patients to let themselves get caught up in the current of the natural processes of bearing witness to human mortality. Colorful scenes of ocean waves or riverine landscapes soothe patients and their families, persuading them this scary place is nothing to fear. Go with the flow; life is river! But the river of sickness and death are managed by the routines of medicine, by doctors and nurses who care for patients and families that face the challenges of grief and loss with all the fear, anger, loneliness, and guilt they bring up. In some ways this river of life is more like a canal. The training of a clinical chaplain begins with this elemental and raw life process that late modern medicine construes as spiritual and natural. The education of chaplains takes place in this clinical space and in one other slightly removed from it. It involves a chaplain's encounters with patients on clinical units, and reflection and dialogue about these encounters with her peers in a group setting where a chaplains reinterprets her story in light of what her clinical practice reveals to her about herself in relation to others. The recipe for clinical chaplaincy education reads: 1) expose human beings and the chaplains who support them to the frailty of their bodies and the illusion of medical control; 2) bear witness to what kind of wisdom and integration happens in response as a chaplain dialogues with her peers who undergo similar training alongside her. The illusion of control is only partially apparent to the clinicians on the unit, chaplains included. Control seems viable until someone dies. In relationship with her cohort, the personal losses of the chaplain commingle with the losses of others she encounters on the clinical scene.

These echoing losses are the muddy ground from which a chaplain grows her identity as a spiritual caregiver.

Clinical Training at Baptist Health

Baptist Health (BH) comprises five hospitals with 11,000 employees and about 200 physician practices. BH is a locally owned nonprofit hospital system, governed by a board of directors made up of Jacksonville community members. The hospital system is rooted in a historical relationship with the Southern Baptist Convention. According to BH's orientation materials, mid-20th-century studies by the Hospital Commission of the Southern Baptist Church indicated that building a hospital in Jacksonville would fill a community need, which led to the filing of a charter in 1947 and the completion of a 125-bed facility in 1955. Though the hospital's affiliation with the Southern Baptist Commission was dissolved in 1979, the hospital maintains a commitment to Christianity that is enshrined in the language of its mission statement: "At Baptist Health, our mission is to continue the healing ministry of Christ by providing accessible, quality health care services at a reasonable cost in an atmosphere that fosters respect and compassion."

Besides its commitment to providing an aesthetically pleasing context of healing through its display of artwork that evokes natural scenes, BH has expressed a commitment to whole-person care that includes physical, mental, and spiritual healing. It has consistently seen spiritual or religious values as integral to biomedical care. Chaplains have ample office space in the Howard Building, and they take a visible role in all orientations and other system-wide trainings and events. They are consulted regularly by senior leaders in the organization. In line with this view, BH began a training program for clinical chaplains in 1980 under the leadership of the Director of Pastoral Care, Bill Brock, who recruited Larry Wagoner, a certified supervisor for clinical chaplaincy training. Because he was a certified supervisor, Wagoner gave BH's chaplaincy training program the credentialed leader it needed in 1983, which enabled the program to attract quality candidates. Thereafter he quickly built up the strength of the department, becoming department head before his retirement, while training cohorts of chaplain residents for over thirty years. After Wagoner retired in 2016, Patti McElroy assumed leadership of the department. McElroy shares the same credentials as Wagoner as a certified supervisor, but she embodies a different set of value commitments that fit with her social location as a lesbian Protestant chaplain. She is neither heterosexual nor male, and in her tenure McElroy has made progress in recruiting chaplains who diversify the department in terms of gender and race. The department remains almost exclusively Protestant, though it now includes both charismatic and mainline forms of Protestantism.

In the early 2000s, BH decided to add another hospital to their system, adding to their flagship hospital Baptist Medical Center Downtown and another smaller hospital named Baptist

Medical Center Beaches. In 2003, BH completed building a large hospital in the expanding and affluent southern part of the Jacksonville at the border between Duval and St. Johns Counties. Baptist Medical Center South (South) has rapidly expanded its lines of service and grown into a 300-bed facility that includes two intensive units, a cancer unit, surgical services, an emergency department, and a pediatric emergency department. The medical complex at South is in stark contrast with the medical complex Downtown in that South has a coherent plan built in stages that were preconceived, whereas Downtown added buildings as new specializations came about and then cobbled the buildings together with passageways. Downtown has an endless and labyrinthine feel that is typical for large hospitals built over many decades. At South, upon entry into the hospital lobby, families visiting patients are greeted by a massive bronze and marble statue standing directly across from the front doors. Gray pleather and grey upholstered couches and low wooden tables fence the statue as natural light floods the furnishings from massive floor-to-ceiling windows. The plaque of the fifteen foot abstract sculpture in the form of a tear drop or strange plant reads: "this original sculpture contributes to our healing environment with flowing forms that are harmonious with the concepts of patient- and family-centered care, unity, resilience and hope." Locally governed hospital system commissioned local sculptor Enzo Torcoletti to complete the magnificent work. The lobby is named for a benefactor, Haskell, and boasts an information desk manned by volunteers and security, as well as a touch-screen directory that can guide patients around the facility. The scene represents the intersection of ecology and medical care, natural order and human controls.

South is known for being less ethnically diverse in clientele and in staff than Downtown, though probably at least twenty percent of its clients and staff are African American. Roughly an equal number are Hispanic, and Asians from various regions are present in more marginal numbers. Growing numbers of Hispanic and African American doctors of both genders serve the hospital, and Asian and Asian American doctors are numerous. While there is considerable religious diversity present, the vast majority of patients identify as Baptist, other mainline Protestant, Catholic, or non-denominational Christians. A sizable minority express views and identify as not religious, agnostic, or atheist. Religious traditions that are non-Western are fairly rare, though I have visited Buddhists, Muslims, Jews, and Hindus on both of the intensive units and throughout the hospital. In most instances, after checking in with patients and families to ensure they are capable of coping with their illnesses and stabilizing them if they are not, my service to non-Christians means liaising with religious leaders from their communities who can come to the hospital to provide them with access to rituals for healing, coping, or dying. This can also be the case in my service to Roman Catholics, who may want to receive a sacrament that I do not have the religious authority to provide.

Nonetheless, clinical chaplains are trained to endeavor to serve any person in a clinical setting. They serve in an interfaith capacity and are specially trained to embody a pluralist sensibility. They undergo training at accredited educational centers in order to become qualified for board certification. A board-certified chaplain (BCC) has completed four units (1600 clinical hours) of clinical pastoral education (CPE) under the guidance of a certified supervisor. The certified supervisor and the board-certified chaplain receive their certification from the Association of Clinical Pastoral Education (ACPE) and the formal designation for a supervisor's credentials is "ACPE Certified Supervisor." For a program like BH's CPE Residency program to be able to attract chaplain residency candidates, it must retain its accreditation as an ACPE center. This is a widely respected brand of quality in the training of chaplains, which enables chaplain residents to find job placement in a clinical institution after they complete training. In line with the standards developed by the ACPE, the residency year that chaplains undertake includes four interlocking modes of training. Chaplains residents visit patients during clinical hours, engage in theological reflection through writing and presentation projects, present cases to the other five members of the chaplaincy cohort and their supervisor and mentor on particularly problematic visits, and interact in unstructured group processes (known as Interpersonal Relations Group—IPR—in chaplaincy training) in which supervisors facilitate group conversation to train group member awareness on how they, in a way that is both natural and reinforced by late modern culture, avoid processes of grief and loss.

Chaplain residents enter the program with hopes of spiritual growth and greater prospects of employment as a spiritual care professional credentialed to work in a healthcare system. As my resident cohort and I prepare for our resident level II consultations, we are evaluating our performance with reference to nine standards developed by the ACPE. In order to qualify for board certification, we need to advance from level I to level II capacities. The ACPE has categorized individual standards in three categories: pastoral formation, pastoral competence, and pastoral reflection. The level II consultations evaluate a chaplain's practice based on a case study (verbatim), clinical reflections, and a statement of pastoral theology. This suite of clinical theological self-expressions and the dialogue between a committee of three chaplains (at least one certified chaplain supervisor and at least one board certified chaplain) and the level II candidate. One standard in the pastoral formation category reads: "articulate the central themes and core values of one's religious/spiritual heritage and the theological understanding that informs one's ministry." In light of this standard, the resident would propose that her self-expressions show a growing awareness of the themes and values of her own theological heritage. If she is claiming that her chaplaincy is an expression of Christ's healing through His own brokenness, she may present a verbatim, a detailed case study presented to one's training cohort, that manifests this dynamic in both its helpful and harmful aspects. The core capacity that the committee evaluates

is how well the resident uses her knowledge of herself in relation to others to provide care. They look with disfavor on blindnesses that cause harm to patients, families, and caregivers themselves. If these blindnesses are sufficiently unremarked and harmful, the committee may require the resident to spend more time at level I before she advances to level II and board certification.

CPE scripts a process for self-transformation and provides the clinical context in which to refashion experiences of loss into useful resources for a ministry of presence. The scripting of chaplain identity then promotes new ways to relate to and use emotional content and process to provide attentive and attuned care. For example, my second CPE unit included fourteen weekly reflections, six case studies, one self-evaluation, one supervisor evaluation, and one family systems project compiled over the course of fourteen weeks. This process of making experience into texts is fairly typical for CPE residencies. At BH, like at most accredited training centers, each CPE unit takes place over the course of fourteen weeks, and in the course of this unit the CPE student identifies learning goals through self-evaluation and monitors progress in meeting them, both in reference to standards delineated by the ACPE. In the unstructured group process, supervisors directly challenge group member strategies of avoidance of difficult or painful reactions and memories in real time as group members relate. The intention behind supervisor challenge is to elicit student empathy in the moment. The structure of the program, including the guidance of the supervisors, is designed to hold chaplains-in-training responsible for caring for others, including patients, chaplains, clinicians, other members of their cohort, and themselves.

Articulating Patient and Caregiver Experience

Clinical pastoral education training hinges on training clinical chaplains to channel their empathy into the provision of spiritual care. One of the underlying premises of CPE at Baptist Health, and for the training of clinical chaplains more broadly, is that the chaplain's unique patterns of joy, love, grief, and loss create rich qualities of emotional experience and personal narrative that the chaplain can use as a resource to empathize with patient experiences. The chaplain supervisor draws the students into greater awareness of their own joys and losses, their emotional responses to them, and how these joys and losses prepare them to feel resonances in encountering patients of various social and cultural locations. What does it mean when a black woman Protestant chaplain who lived through a divorce provides spiritual care to a white man who lost his wife to alcoholism and is now avoiding grief through pleasure seeking? How might a white male Protestant chaplain who lost a sister to a terminal disease when he was young provide spiritual care to a non-religious family who faces losing a child to cancer? What are the places were these chaplains, patients, and family connect emotionally and theologically? Conversely, what prevents these particular chaplains from feeling empathy for these particular patients and fami-

lies? How does dialogue about these encounters in group deepen the learning of all six members of the cohort and the supervisor? What does this say about the responsibility to care for others? These questions become explicit and answerable as an outcome of the dialogical training in which chaplain residents engage. The motivation of these residents is to use these encounters for personal transformation that contributes to the healing of patients, families, staff, and themselves.

CPE training assumes that the differences in social location between a patient, family, and chaplain can interfere with a chaplain's ability to empathize with a patient and her family. But chaplaincy training also assumes that social differences cannot ultimately prevent a chaplain from empathizing with a patient or family. These two assumptions express the basic understanding of many psychological frameworks influential in the origins of the clinical pastoral education movement: that human beings living in late modern US culture share many experiences as well as modes of thinking and emoting in relation to them. This is not to say that differences in social location do not produce sharply divergent human experiences. CPE training also assumes that speaking about these experiences is the means by which persons suffering from feelings of loss can become aware of, work with, transform, and free themselves of negative energies that accompany grief. The training that chaplains undergo reinforces the notion that human beings can master loss and reintegrate themselves through verbalization of the emotions, thoughts, and images that loss evokes. CPE practices hold that the narration of past losses offers the possibility of healing. It holds chaplains accountable for becoming aware of, resonating with, evaluating, and transforming their personal losses.

CPE interlinks patients and chaplains as well as patient families and other clinicians. The chaplain will work with patients of various social types, community affiliations, and biographies who face loss; she will bring to bear her own sociological, psychological, and theological evaluation of and reflection on what those losses evoke in the patient, family, clinicians, and herself. The training explores the sociological, psychological, and theological implications of these encounters in the medical context. In relationship to others and the losses to which they respond, the inner subjective experiences of the chaplain come alive or awaken, making them amendable in a process of intersubjective growth and integration that benefits both caregiver and those to whom they give care. In this way, clinical chaplaincy treats caregiving as related to the inner resources of patients, families, clinical staff, and chaplains. The training encourages chaplains to use their personal, social, and theological resources to connect with patients in order to support them emotionally, cognitively, and spiritually.

Clinical pastoral education invites chaplains to express their authentic selves in acts of empathy and compassion. It provides discourses to frame encounters with patients as theological, psychological, and social and it enjoins chaplains to constitute, interpret, and symbolize their experience through these discourses. Through the process of visiting patients, reflecting on these visits

in verbatim presentations, dialoguing about these visits with colleagues with whom they have built rapport, and becoming aware of their strategies to avoid loss and other personal biases, chaplains engage in a process of refining their personal and pastoral identity as an authentic caregiving self. In relating experiences of patient-chaplain encounters and aspects of the chaplain's self that enabled or hindered emotional and spiritual connections, the chaplain cohort is attempting to assign the reporting chaplain responsibility for giving spiritual care while also empowering her to do so more skillfully. The unique and personal caregiving self involved in this practice of responsibility is whole, integrated, and authentic. It is capable of understanding how social location influences care while maintaining an essential capacity to relate to colleagues, patients, and families of diverse backgrounds. Clinical chaplains who complete residency are held to be rooted in their own religious tradition and at the same time capable of serving diverse patients and families by providing them with the loving and warm interpersonal space in which to make meaning of their illness experiences.

The caregiver expresses her wholeness and integration through the documentation of her self in a synthetic pastoral identity that draws on religious tradition, case studies, and evaluative reports written by the chaplain herself and her supervisors and mentors. This self is naturally generative of care, drawing on limitless hidden depths that enable responsible action on behalf of others in unfolding clinical relationships with patients, families, and colleagues in a medical setting. As the energy from these depths is translated into caregiving acts in the hospital, caregiver experience is made into a textual forms. The chaplain's work in the residency year is to constitute a pastoral identity in dialogue with her past experiences (including formative losses, other life events, and family history), religious tradition, and personal style. In this effort of defining a pastoral identity, chaplain residents come to know themselves through textual and dialogical interactions with the memories, views, and feelings of their self in relation to others.

Learning in a Community of Spiritual Caregivers

I entered into CPE training at first as an intern in 2011 at Baycare in Pinellas County, FL. Almost all clinical chaplains begin training as interns, which qualifies them to apply for a residency. Internships give chaplain trainees one unit of training (400 clinical hours), while residencies give chaplain trainees three units of training (1200 clinical hours). I began my residency in the final year of my doctoral degree as I completed this dissertation. My decision to enter a CPE residency program came about because of my attraction to working in a helping profession, which was my response to agonizing personal losses, most importantly an abuse history and my divorce. The sorrow, anger, and fear (and other nameless affects and energy flows) that my history of abuse and my divorce have produced in my bodily experience serve as resources for em-

pathizing with patients and families who face losses that might evoke similar responses. Another source of empathy for others that comes from my personal life is my deep love for and joy in parenting my three daughters. My motivation for undertaking CPE training was to use my experiences to serve others with greater skill, and I hoped to transform myself and integrate my experience in the process. Chaplaincy work, and caregiving more generally, plays on the energies of emotional polarities as they animate personal experience and interpersonal interactions. I can sense and imagine the inner world of another because I can sense and know my own inner world, but this ability to empathize is as partial and imperfect as it is powerful. It can lead to unskillful projections as easily as insightful interpersonal connections.

I joined a cohort of five other trainees at BH in August of 2019, committing to a year-long residency under the supervision of Patti McElroy and Samuel Chinn. My residency cohort reflects typical patterns in CPE training and chaplaincy staffing in the Southeast. Five of the six chaplain residents are Protestants, three from mainline denominations and two from charismatic denominations. One of the six chaplain residents is a humanist who is ordained in the Unitarian Universalist tradition and considers herself an atheist. One of the six chaplain residents is African American. Two of the six chaplain residents come from working- or lower-class backgrounds. Half of the chaplain residents face financial insecurity, owing in part to the shrinking wages of ministerial positions and the intense competition over chaplaincy work.

From the very beginning of our time together, group dynamics highlighted interpersonal differences in terms of gender, race, and class figured prominently in IPR. My African American colleague had the courage to say that she felt isolated by her experience as an African American woman very early in the residency year, and we have had recurrent discussions about how race, class, and gender influence our group process and the provision of spiritual care. Race is an important intersectional identity that plays into the relationships of my cohort, but it is only one face of group diversity. Gender, class, and political affiliation play just as important a role, as only one resident affiliates with the Republican Party and two have shared similar stories about the lack of means in their childhood households. Our supervisor is a white Protestant male who embodies privilege even though he works to limit his power and maximizes participation across group members. Beyond these social factors that differentiate the lived experience of my training cohort, each group member has a different relationship to her or his own religious tradition and to religious traditions outside of her or his home tradition. The two charismatic Christians tend to very firmly locate their pastoral identity in the scriptural resources of the Christian tradition, whereas the humanist chaplain welcomes wisdom from any source. The other mainline Protestant chaplain residents read across religious traditions and appreciate spiritual and religious literature from a variety of sources. My own religious upbringing and academic study has exposed

me to literature and practices from Sufism, the African diaspora, and Zen and Tibetan Buddhism, though I remain in the United Methodist Church in which I was raised.

Considerable diversity exists in my cohort, even though we are nominally five-sixths Protestant, and the same could be said of the spiritual care department as a whole. Of the fourteen chaplains on staff at the five hospitals owned by BH, three are African American and two are Asian American. Thirteen are Protestant, all but three are from mainline denominations, and one is Roman Catholic. All but one chaplain, the head of the department, are cisgender and heterosexual. Four of the fourteen chaplains are men. But the diversity in the backgrounds of the chaplaincy staff goes far beyond these demographic markers, and each chaplain brings the wealth of her or his personal experience, cognitive frameworks, and embodied modes to the work of spiritual caregiving in a medical setting. It is especially important to consider the diversity of embodied modes of giving care because of how prominently they figure in this dissertation. One of the central arguments that I am making is that mindfulness meditation practice delineates a pathway to intimacy with oneself and others that produces qualities of care differentiated from liberal Protestant modes of embodiment. These qualities emphasize the spaciousness and clarity of the mind as the receptive space in which bodily sensations and feelings appear and can be refashioned for the purposes of empathy. A contemplative chaplain can feel the pain and agony evoked in herself with less avoidance when she encounters another who suffers. Contemplative practices are not the only way to develop empathy, but they are one particularly well-researched way that is undertaken by the community of American Zen chaplains whom I researched.

The Paradox of Spiritual Care

Clinical chaplains provide spiritual care to a population that I divide into three groups relative to their views about the place of religion in healing: 1) patients who believe religion has no effect in healing and perhaps no basis in reality; 2) patients who see the chaplain as capable of providing comfort or psychosocial healing that does not effect a physical cure directly; and 3) patients who believe that chaplains and other clergy can effect supernatural healing. At least one-fifth of my visits on the intensive care unit involve requests for healing that I would describe as miraculous and sometimes nearly impossible from the medical standpoint. The belief in the power of prayer as healing speech continues to hold in the contemporary population of patients at BH facing medical crises. Patients who believe that chaplains can offer comfort associate spiritual care services with views of illness that include the notion of surrender to God. Some patients in both of the second two groups express their understanding of God as the ultimate judge and arbiter of personal fates, a God who plans human footfalls along a given path and counts the number of hairs on the patient's head. These patients believe it is their task to accept obediently what

God determines will happen in their lives. The chaplain serves as the intermediary of God, and these patients want her or him close to procure both comfort and healing. By contrast, some patients prefer not to interact with a chaplain, either because they have their own community of faith praying for them, they are angry with or feel disconnected from God, or they hold atheist or agnostic beliefs.

Typically, mainline Protestants feel comfortable receiving spiritual care from any Protestant chaplain, as do most Roman Catholics. Jews and Muslims require special services that usually entail them asking the chaplain to connect them with outside clergy if they are not already so connected. I have had very meaningful visits with Jewish patients and families, even though I cannot provide the services they require. I have been respectful and listened with curiosity to them describe the meaning of their lives in relation to their presenting illness or other crises. They have shown reciprocal respect for me and my limits, given my rootedness in Protestantism, in providing them with spiritual care. Atheists and agnostics often receive a spiritual care visit as a symbol of the hospital's concern for their spiritual orientation and sometimes they decline spiritual care services altogether. Hindus and Buddhists are far too rare for me to have much expectation for what they require of me as a chaplain. Most interfaith chaplains, and I would include myself in this set, see themselves as capable of providing free access to religious services to each group of people described above, but this is often a rather complicated and imperfect endeavor. Much variability exists between individuals in each faith tradition I have named above, and the notion that chaplains can serve all persons in medical institutions is an ideal of pluralism hard to effect in practice.

As a liberal Protestant, I do not often find myself personally and theologically gravitating toward the view of the world as saturated with supernatural or miraculous healings. This is not to say that I believe that these healings do not take place, and claims to the contrary are quackery. Despite my personal inclination not to see miraculous healings as an ontological feature of reality, my responsibilities as a chaplain include praying for miraculous patient healing even in circumstances when I believe that to be impossible. I do this because I find that when I receive patients and families in their need, even a need for something I am not sure can happen, they more quickly come to accept the objective facts of the case when it becomes obvious our prayers were not answered. I often find myself praying for healing and maintaining my sense that God can work miracles when I sometimes cannot envision that healing take place. I offer prayers resolutely hoping that the patient and her family will be spared suffering, pain, loss, and heartache. Hours or days later, it will be my responsibility (or another chaplain's) to persuade them that God has chosen to answer their prayers with a course of action that they did not expect or hope would come about. As much as I offer prayers for an outcome that patients and families name, I hold

these voiced requests in tension with the ultimate mystery of God expressed in the objective facts of life and death in the medical scene.

The paradox of spiritual care is that the chaplains in my residency cohort have learned the most from encounters that bring them to the brink of interpersonal, emotional chaos and personal devastation, in which case they have no power to say or do anything helpful. At the limits of human agency, clinical chaplains embody an abiding spirit—a spiritual presence. On the one hand, in the most difficult circumstances patient hopes for miraculous cures and requests for prayers supplicating miracles often call forth the chaplain's earnest prayers for God's miraculous healing so that patients can be spared from death or loss. On the other hand, it is frequently in the moments when groups of person in community face the tragedy of loss with courage and compassion that I have seen God's most precious gifts lavished on patients, families, other staff, and myself. While they give patients a new lease on life, miraculous healings can merely forestall the wisdom that comes from surrender. Miraculous healings may also give the family a bit more time to get their affairs in order, allowing for meaningful conversations between persons who love each other very much but may have neglected to say so. The paradox of my experience in providing spiritual care is that healing of the physical body may work against the freedom that comes when patients and families surrender without expectation about what God will do. This creates a tension in the work of providing spiritual care, distinguishing two contrary movements. That is, the chaplain's maturation as a spiritual caregiver through exposure to suffering—coming near to pain, loss, grief, sorrow, anger—contrasts with the natural desire of patients, families, and caregivers (chaplains included) to avoid suffering. I have not yet met the spiritual or medical caregiver who openly admits to wanting others to suffer or believing suffering is justified because it is one of the most powerful ways that humans learn. At the same time, suffering will inevitably appear in the lives of patients, families, and caregivers and a substantial part of chaplain training is learning to work with this suffering: thus the focus on learning to accept and work with thoughts, feelings, and affects related to suffering.

Medical Routines and the Place of Feelings

The clinical chaplain's day at South begins with morning report at 8:30 am in the seventh-floor pastoral care office. What distinguishes the chaplain resident from staff chaplains is the amount of time that residents spend in group learning processes, gaining insight into themselves through dialogue. On days when residents do not have class but visit patients all day on their units, the difference between a staff chaplain and a chaplain resident has only to do with the amount of experience they have and the difference in wisdom and maturity that likely entails. Residents are more likely to find themselves in shock or deep sorrow because of their relative

lack of experience. For example, at the beginning of my second unit I almost fainted when I responded to a call to the Downtown ICU. A patient was coding (suffering cardiac arrest), and as I looked into his jaundiced eyes, he yelled "This is a nightmare!" His anguish sent my gut reeling in fearfulness that mirrored his fear, and I had to drop his hand and walk out of the room to make sure I did not lose consciousness. I returned to the room to visit and support the family after I had recovered my poise, but the patient (to my knowledge) never regained consciousness.

All the chaplains for the entire system, serving five hospitals in different locations, call in to a telephone meeting to participate in giving "report." The on-call chaplain at Baptist Downtown organizes the meeting by first enumerating the pages that she received during the twenty-four hours previous to the call. She then invites other on-call chaplains at the four remaining hospitals to enumerate the pages to which they responded. One of the main purposes of morning report is the notification of chaplains on particular units, such as the Neonatal Intensive Care Unit (NICU), for follow up visits or handoffs. At the same time, morning report gives the department, and the individuals who comprise it, a sense of corporate identity and solidarity. This isn't to say that most chaplains pay close attention throughout the meeting, as a certain critical mass doodle or drift in reverie as the on-call chaplain reads the litany of time, name, room number, pastoral care service, and follow up. Most mornings a chaplain or two fingers her or his smart phone as morning report takes place.

After finishing report, my fellow resident colleague and I walk to our office and chat about events from our class days in group learning or important happenings in the hospital system. Every weekday, two chaplain residents, a staff chaplain, a part-time chaplain and at least one chaplain intern serve South. We often catch up on system-wide news after giving report. Tragedies involving hospital staff or unusual cases happen every so often, and they cause a ripple of scuttlebutt in the spiritual care department for a few days. We check our emails and then plan our work for the day before heading to our different units. In the morning between 9 am and noon, I begin with the most intensive unit and attempt to visit every patient on it, usually between eight and twelve souls. I often work around the visits of other clinicians, and I drop in when other family members or friends are present. I may postpone a visit till later in the day if the patient seems so busy with diagnostic tests or clinical treatment that they will have little attention to focus on their spiritual or emotional issues. Most clinicians have scrubs that designate their role (royal blue for nurses for instance), but chaplains are dressed in business casual attire, and I have been mistaken for a doctor many times. Many of the patients on the intensive care unit (ICU) cannot breathe without a ventilator, and I spend as much time talking to family as to patients themselves. Family members facing illness first think of healing, and many family members believe that their loved one will receive healing once chaplains and other clergy have lifted up words of supplication. I connect with nurses and other staff throughout the ICU as we

go about our work, sometimes checking in with them about their spiritual needs or emotional state. We also talk more formally about particular cases. On occasion I receive a call or a page for a code or another medical crisis in the event a patient goes into cardiac arrest, respiratory distress, or experiences a fall or loss of consciousness.

By the middle of the day, I finish working in the ICU and meet my colleague for lunch in the hospital cafeteria or the Starbucks next to the Baptist South Serenity Garden. We descend to the first floor in the tower elevators together and talk idly, greeting patients, families, and staff as we go. Since we are not dressed in a uniform, people we meet do a double pass on our name badge to see where we belong. Their faces usually ease when they identify us as chaplains. We eat together and discuss our group dynamics or the ordination processes in our respective churches. More often than not, my colleague and I find group process and ordination challenging, frustrating, and enriching. After we finish, we sit in silent prayer for five minutes before heading back into the clinical scene. I move from the most intensive unit to the progressive unit where surgical patients are monitored post-operation or where patients from the ICU are downgraded for observation. After making my rounds, doing my best to visit every patient on the unit at least once during their stay, I return to patients who may need more intensive spiritual care as determined by my spiritual assessment. In between visits, I share news with nurses and other staff or check in with them about how their work is going. I end my days at 5 pm, heading to pick up my children when I have custody or going home or to the YMCA on days I do not.

During my first few weeks, nursing staff treated me with the hurry and bustle of efficient caregivers, taking only enough time to be polite. After I responded to several deaths, once with a woman who wailed so loudly she could be heard throughout the unit, ICU staff realized that I would be willing to draw close to people in pain. They have become more candid with me as they realized they can trust me. Each team of nurses that I support, defined by unit, value caring for patients, but they feel often feel overburdened by the responsibility to care even in a well-resourced medical institution that provides ample support for caregivers. Group process and clinical work brings to awareness the presentation of emotional life in facial expression and body language, and the clinical chaplain is encouraged to verbalize what she observes in herself in response to others. She does this to invite elaboration from conversation partners. This may be as simple as saying, "You seem anxious. How are you doing today?" This is an invitation for the elaboration of one's feeling life that is secondary to the norms of discourse dominant in medical institutions, which focus on rational, bureaucratized methods to apply medical knowledge to clinical problems.

Much of the time, the medical staff thirst for a place in which to share how they feel about the medical care they are providing and the impacts it has on the patients and families they serve. They desire a place to lament particularly tragic cases, for instance when a young white middle-

class mother who was a teacher suddenly had a stroke and died, leaving an overwhelmed husband and three children bereft. Or perhaps they find the senseless overdose of young black woman who had just graduated high school and the shock and numbness her parents felt particularly troubling. The ICU that is my primary unit has felt the aftershocks of these two particular losses, which left the nursing staff feeling vulnerable and disturbed by the intensity of the pain and loss that patients and families felt. Speaking from my own experience, the loss felt bitter and left me sensing a tenderness toward the patients, families, staff, and myself. The tenderness I felt does not in any way serve as a justification for the suffering. It is merely an aftereffect of the helplessness and vulnerability of watching persons die in a way that does not strike me as fair or meaningful. It is born from watching families mourn the tragedy of losing irreplaceable and unique persons, pouring their grief out in ways that were messy, wet, and volatile. As a community of caregivers, we did our best to face and bear witness to these hard realities of human life lived in fragile bodies and then we moved on with our days.

The ICU at South is in the shape of a rectangle with large rooms on three sides into which clinicians can look through glass windows from the hallway. Because each room can be seen into from the outside through glass windows, actions in the room have the feel of taking place in a museum exhibit or on a stage. I often lose awareness of this quality of being watched when I focus on what is taking place with patients and families interactively, but it occurs to me when entering and leaving rooms. The rooms have curtains that patients, staff, and families can draw to have privacy. The ICU is on the fourth floor of Tower A. Close to the primary nurses' station, where the unit clerk sits, four rooms hold the most critical cases. Perpendicular to these four rooms a hallway with eight rooms extends toward an auxiliary nursing station, and then the last four rooms are on the backside of the unit. At the ends of this longer hallway are two rooms for family conferences, the smaller one closed and the larger one open. Chairs cluster in the open room, and the smaller room has a couch and chairs. Another family room with tables, a television, and a coffee machine is at the entrance of the unit. Countless discussions with mourning families have taken place in these rooms, which is where the majority of my most poignant chaplaincy encounters have happened. All the patient rooms and family conference rooms have large windows that look out on green, landscaped grounds. The unit has computers at small desks between each pair of rooms where nurses and staff chart when they are not using a mobile computer called a WOW (Workstation on Wheels).

Each room in the ICU has a hospital bed, the necessary equipment for a ventilator, heart monitor, and drug treatments of various kinds. A small desk with a chair is nestled next to the wide windows looking down on the outside world, a dry erase board, a sink, a toilet, a couch, an easy chair, a mini refrigerator, and a wardrobe built into the wall. On the wardrobe is a small flip chart that describes the patients in his or her own words. A television monitors the scene with

controls for volume and a call button for the nurses' station on a remote that lies on the bed. Each room also has a phone that plugs into the wall that very rarely receives any use. Families often sit on the couch, and many family members sleep at the hospital with their loved ones. Around four-fifths of patients are accompanied, at least part of the time, by family or friends. Patients unaccompanied are especially appreciative of chaplain visits when they are cognizant enough to take notice of them. Nurses on the ICU usually interact with patients in a way that demonstrates care. They frequently make eye contact with patients, show concern through their facial expressions and tone of voice, and spend considerable time talking with patients, though they have documentation demands that mean they have to be efficient with their time. A small percentage (about one-fourth) pray with patients who welcome prayer. The majority of the nursing staff are Christian, mostly Protestant, though some of the nurses express atheist or agnostic views. Some of the nursing staff are also Catholic. A few of the doctors express Christian views, while most are reticent about discussing their own religious or spiritual life with other staff members or with me. The ethos of the unit is team oriented, supportive, and interactive. As a rule, doctors welcome nurse feedback and take into account the views of the nurses, dietitians, respiratory therapists, and pharmacists who work on the unit. Chaplain input is welcomed but typically marginal to the clinical discussions that take place during clinical rounds.

This is largely because clinical chaplaincy occupies a marginal space in biomedical institutions. Clinical chaplaincy is at the margins of three separate discursive worlds: 1) medical discourse, 2) theological discourse, and 3) psychological discourse. The position of chaplaincy as a discipline at the margins and intersection of these disciplines and their ways of speaking, writing, telling stories, and marshaling knowledge is symbolized by the place of chaplains in clinical units and their relationship to their endorsing communities of faith. The standards of the ACPE require that a chaplain maintain good standing with and receive the endorsement of her faith community, which often requires meeting with the governing bodies of the church community regularly. Chaplains also complete board certification by training in clinical settings through a CPE residency at an accredited center. During this residency year, chaplains are exposed to various forms of psychosocial knowledge such family systems theory, psychological writings on grief, transference/countertransference, and the like, and frameworks for theological reflection. Chaplains learn the clinical terminology and the various plans of care for common medical problems on the units they serve. In relation to doctors, who wield the most power to hold clinical staff responsible to a strategy and plan of care (care in a medical and interpersonal sense), chaplains practice a form of care and healing little understood and viewed as auxiliary. The paying institutions that underwrite medical care often do not reimburse for spiritual care services directly, which means chaplaincy can be seen as an afterthought even in holistic institutions of medical care that have respect for spiritual care like BH.

The physical space of the unit and my daily movements across it symbolize this marginal status of the chaplain. I am often in patient's rooms at least four-fifths of my time on the ICU. Doctors, even highly involved and compassionate ones who sit down in patient rooms and engage with patients at the same physical and cognitive/emotional level, spend five to ten minutes in patient rooms when they visit. Doctors also have the most authority to access spaces across the system and leave the bedside. They are empowered to fly across the boundaries that divide units and I see them crisscrossing the clinical landscape of the hospital. Sometimes doctors show great compassion at an unexpected and heartbreaking death (say when parents lose a young child); they may spend considerable lengths of time commiserating with patients and families. Nurses spend more time in patient rooms than doctors, but again only ten or fifteen minutes at a stretch, most of which is organized around clinical tasks. This means that nurse communication is directed by the plan of care set by the doctors and executed by the nurses. Patient concerns are taken into account, but are predominantly considered secondary to the plan of care. The majority of the time, chaplains spend at least fifteen to twenty minutes looking directly at patients and asking them open-ended questions about their experience. In the language of American Zen, chaplains bear witness to patient and family joy and suffering as a spiritual practice.

The same general pattern holds for the organization of spaces on all the hospital floors, which is evident in the layout of the ICU. Nurses spend the majority of their day moving between the rooms to which they are assigned and their WOW in the hallways. The charge nurse is responsible for overseeing the nursing staff as a unit and stays near the vital sign monitors in the main nursing station. The doctors spend the majority of their time orienting patient plans of care by studying medical information, receiving and interpreting images, or consulting with specialists. The spaces of the ICU can be represented as two largely segmented domains with two threshold zones in between. On one side, 1) patient rooms (least medically controlled and highest likelihood of emotional chaos) abut 2) hallways and WOWs (frontline medical control and transitional space of emotional chaos). On the other, 3) the nursing station (mediating place of medical control that translates care into medical discourse and distant from emotional chaos) abuts 4) the doctor's consultation room (medically controlled and removed from emotional chaos). Medical staff may cross over any of the zones, but chaplains spend more time in patient rooms, nurses an intermediate amount of time in patient rooms, and doctors the least amount. All of this is to say that the chaplain's position in this medical world encourages her to prepare herself to serve as the spiritual presence that comes near to the chaos of old age, sickness, and death.

Chapter 2

American Zen Expressivism and Ecological Spiritual Care

> Spirituality emerges over and over in our collective imaginations as free floating and individualistic. Spirituality appears to be a condition of modern life: it has no past, no organization, no clear shape.
>
> —Courtney Bender, *New Metaphysicals*

> Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another.
>
> —Christina Puchalski, "Spirituality in Healthcare"

The rise of Upaya Institute and Zen Center (UZC) has come about in part because of many social and historical conditions falling into place by the early 1990s, but here I focus on three essential factors in understanding why the *dharma* taught at UZC has been so readily translated into the medical scene of late modern hospitals. First, Joan Halifax grew up in an age when communities of liberal Protestants read widely across religious traditions and modern scientific disciplines. From the 1920s to the 1960s, these practices of religious reading enabled the cross-pollination of religious ideas in liberal religious communities—Roman Catholic, Jewish, and Protestant. Second, spiritual seekers since the late nineteenth century established a pattern of spiritual exploration that became the hallmark of the promiscuity of the most progressive fringe of liberal religion. Spiritual seekers like Halifax, trodding a path similar to Sara Chapman Bull or Sarah Jane Farmer, wanted to gain access to religious experience that differed from the spirituality and religiosity of their upbringing. They often sought after alternative forms of consciousness that differed markedly from the intense rationalism of modernity. Third, Halifax's exploration of her identity through forms of writing expresses a wider cultural trend influenced by Romanticism that assumed human persons created an identity through self-inventive narration. In this way of understanding how human persons come to be in American culture, practices of storytelling embodied the core means by which a person fashioned an identity. Thus, through her writings about herself, Halifax has interpreted *buddha* nature as the extended self, displaying how the self-expression at the heart of Zen shows the influence of Romanticism, which broadly permeated American religious communities, especially religiously liberal ones. In the first section, I will reconstruct how Halifax's identity combines religious reading practices and seeker spirituality.

Next, I will relate these two features of her religious identity to the broader sociocultural pattern of self-expressive narration. These particular histories provided Halifax with ripe social conditions in which to creatively integrate discourses of ecological selfhood into the practice of clinical chaplaincy.

New Ideas and New Practices: Religious Reading and Seeker Spirituality

Halifax's conversion to Zen Buddhism in the 1960s came about through two distinct phases: 1) first she read literature on Zen philosophy by Alan Watts and D. T. Suzuki that exposed her to the world of Zen ideas; and 2) then she entered into a formal relationship with a Zen teacher and a particular school of Zen. The exposure to Zen philosophy introduced her to ideas about the nature of reality that appealed to her, but it was only after she engaged in contemplative practices that radically changed her experience and personhood that she emerged as an iconic voice in American Zen. These two distinct moments in Halifax's personal biography suggest that both the reading practices of religious liberals, in Halifax's case liberal Protestantism, and seeker spirituality played an important part in Halifax's defection from the belief system of her forebears. Religious reading practices came about in the first half of the twentieth century as the outcome of concerted efforts between state actors and religious communities. Religious reading enabled the exchange of religious ideas across communities of religious liberals. Seeker spirituality, which had its roots in both Transcendentalism and Romanticism, arose as the consequence of the encounters of an avant-garde of American intellectuals and interfaith explorers with the religious systems of East and South Asia, occult religiosity, and indigenous religion in the Americas. As the experiential complement to religious reading, seeker spirituality valued the exploration of alternative religious practices that extended beyond engagement with religious texts as sources of information. Because I see these two processes as a historically and ontogenetically interlinked sequence in which religious reading precedes engagement in religious practices like meditation (which is the sequence manifested in Halifax's biography), I will treat religious reading first and then discuss seeker spirituality next.

Religious Reading Practices and Interfaith Dialogue

Religious reading practices in the first half of the twentieth century were transformed by the increasingly liberalized circulation of interdenominational and interdisciplinary works, exemplified by the work of the Religious Book Club (RBC). These new practices were a cornerstone of American religious liberal communities and were supported by both religious and state institutions aiming to promote liberal ideas and support a pluralistic society. Groups of progressive out-

liers like the Transcendentalists anticipated the more widespread trend among religious liberals to openly engage with religious knowledge, beliefs, and practices that do not originate in Christianity or Judaism. Religious reading practices, in the way that I am using the phrase, meant reading books on religious beliefs and practices outside of one's faith tradition and reading scientific books that could be integrated into one's faith perspective. For example it meant that liberal Protestants read books by Abraham Heschel and Thomas Merton, while liberal Roman Catholics read books by Harry Emerson Fosdick and Martin Buber, and so on. Similarly, religious liberals from Catholic, Jewish, and Protestant communities read books on psychology, mysticism, and the study of religion by authors like William James, Harry Stack Sullivan, or Ralph Waldo Trine. Religious reading practices brought extended explorations of fringe and alternative religiosities into the mainstream. As Protestant, Catholic, and Jewish communities exchanged ideas about psychology and religious beliefs and practices that included South and East Asian religions, this open exchange enabled clinical chaplains to integrate psychological discourses with religious knowledges into pastoral care.

After the end of the Civil War, reading practices facilitated the exchange of new ways of constituting religious identities in mainstream and alternative communities, and these reading practices were shaped significantly by state-church partnerships. Within the religious mainstream, reading practices shaped the content of religious discussion, interpersonal dynamics, and ways of relating to new scientific knowledge in Protestant, Catholic, and Jewish houses of worship. In addition, reading practices played an instrumental role in the development of alternative communities of religious or spiritual practice that organized themselves in a more acephalous way, as in the example of spiritual seekers, modern yogis, or twelve-step recovery groups.[1] Reading practices generated the demand for print cultures. Ongoing interaction with print cultures cultivated in reading publics implicit norms of knowledge acquisition (one learns content one might not integrate into behavior) and values (one is open to other faiths). Reading practices instructed members of religious communities how to constitute themselves in a particular way as part of a particular kind of community with particular logics of organization and value constitution. From the 1920s onward, early chaplains like the founder of the clinical pastoral education movement, Anton Boisen, formed their identities in such a way as to enable incorporation of religious and scientific knowledge. Historian Susan Myers-Shirk proposes the apt term "liberal sensibility" for the widespread receptive disposition constituted by reading practices, shared by liberal Protes-

---

[1] Matthew Hedstrom, *The Rise of Liberal Religion: Book Culture and American Spirituality In the Twentieth Century* (Oxford, New York: Oxford University Press, 2013); Trysh Travis, *The Language of the Heart: A Cultural History of the Recovery Movement from Alcoholics Anonymous to Oprah Winfrey* (Chapel Hill: University of North Carolina Press, 2009), 1-17; Elizabeth De Michelis, *A History of Modern Yoga: Patanjali and Western Esotericism* (New York: Bloomsbury Academic, 2005); Stefanie Syman, *The Subtle Body: the Story of Yoga in America* (New York: Farrar, Straus and Giroux, 2010).

tants.[2] The liberal sensibility is a disposition of openness to diverse religions and scientific views, which brings to the fore the common ground shared amongst progressives that urged learning how to incorporate religious and scientific diversity into one's religiosity.

The liberal sensibility created by religious reading practices in communities of religious liberals created a sense of many differentiated options for the self-constitution of a faith identity developed through dialogue and encounter. The pluralist principles of the United States allowed for a fairly broad diversity, but this diversity was founded in the normative conception of these diverse views as sharing a monotheist outlook. Secular institutions like hospitals and the military, socially differentiated from religious institutions, provided the differentiated secular spheres in which interfaith dialogue, often framed in terms of psychological discourse, took place. Dialogue was governed by policies that reinforced liberal Protestant hegemony while at the same time expanding Protestantism beyond its bedrock in theologies of the Reformation into new liberalized and modernized forms. For instance, the military chaplaincy during World War II created a sense of "moral monotheism"[3] that allowed for diversity within monotheism while it consolidated the position of the tri-faith orthodoxy of Protestantism, Catholicism, and Judaism. Historian Ronit Stahl writes:

> after two decades of crafting an ecumenical vision for the American military chaplaincy, chaplains understood that their responsibilities included ministering to Protestants, Catholics, and Jews alike. They recognized that religion and patriotism could be linked, with God, country, and brotherhood coalescing into a state-supported religious adhesive critical to national defense.[4]

In the era of its inception, in a way that is similar to military chaplains, modern clinical chaplaincy encompassed variant monotheistic views that supported the operations of medical institutions. What is essential to recognize is that liberal Protestants, Catholics, and Jews who supplied clinical chaplaincy with its first caregivers were in the habit of treating their experiences in the rationalized bureaucracies of the state and parallel social institutions as part of their religious and/or spiritual experience. They viewed their lives as divinely inspired, and learned not to speak of those inspirations in proselytizing ways in secular contexts.[5] In this work of verbalizing faith in

---

[2] Susan Myers-Shirk, *Helping the Good Shepherd: Pastoral Counselors In a Psychotherapeutic Culture, 1925-1975* (Baltimore: Johns Hopkins University Press, 2009), 10.

[3] Ronit Stahl, *Enlisting Faith: How the Military Chaplaincy Shaped Religion and State in Modern America* (Cambridge: Harvard University Press, 2017), 52-53.

[4] Ibid., 72.

[5] See Courtney Bender, *Heaven's Kitchen: Living Religion At God's Love We Deliver* (Chicago: University of Chicago Press, 2003) for a fascinating study of indirectly religious talk in a secular nonprofit in the United States during the late modern period.

non-proselytizing ways, psychology provided the language for translation between religious community and the secular medical context.

The broad variety of views that clinical chaplains encountered in their clinical practice and communities of faith meant that they needed grounding in the historical theologies of the church but also openminded curiosity about variant spiritualities. Hybridizing liberal theologies generated many styles of view about spiritual entities continued presence in the secularizing modern world, including forms of religious enchantment, mystical psychology, or healing ministries linked to healing cults (New Thought, Christian Science, Spiritualism) as well as institutions of medical care.[6] The key point is that such views about spiritual actors' presence behind the labor of military or medical institutions were either propagated, supported, or at the very least tolerated by partnering government and religious institutions. A particularly elucidating example of this history of collaboration between religious institutions and the state is central to historian Matthew Hedstrom's interpretation of the rise of liberal religion. Hedstrom documents how church-state partnerships were largely responsible for the creation of mystical psychology in liberal religious circles through the formation of the Religious Book Club (RBC). This collaborative project between various ecclesial actors of different faith traditions organized religious discourse and rational debate in the same era in which modern clinical chaplaincy came into being. The preference for religious liberals in state institutions manifested in the predominance of non-proselytizing liberal Protestants in the military, hospitals, and prisons, where the three-faith orthodoxy was normative. Since its inception in 1926, the RBC provided a selection of the most important religious books for single consumers as well as academic and public libraries to purchase. The RBC was the outcome of efforts led by Samuel McCrea Cavert of the Federal Council of Churches (FCC) to guide the reading practices of groups of church members in liberal Protestant, Catholic, and Jewish communities. The work of the RBC continued to affect liberal religious communities into the 1950s because it flooded the libraries of these communities with a variety of books that espoused liberal positions couched in discourse that formed the thinking and speech of religious liberals.

The RBC created institutions of religious education through the formation of a cannon and establishment of local reading groups that in turn reinforced the notion of a religiously liberal nation in the imaginations of religious liberals who belonged to Protestant, Jewish, and Catholic religious communities. Print capitalism made religious literature affordable for most of the middle class, and religious book clubs exercised subtle authority in orienting the pluralist views of

---

[6] Anne Braude, *Radical Spirits: Spiritualism and Women's Rights In Nineteenth-Century America* (Boston: Beacon Press, 1989); Hedstrom, *Rise of Liberal Religion*; Pamela E. Klassen, *Spirits of Protestantism: Medicine, Healing, and Liberal Christianity* (Berkeley: University of California Press, 2011); Beryl Satter, *Each Mind a Kingdom: American Women, Sexual Purity, and the New Thought Movement, 1875-1920* (Berkeley: University of California Press, 1999).

their members. The RBC encouraged broadminded religious literacy through informal reading groups and social institutions. For example, the American Library Association (ALA) came to rely heavily on the recommendation of the RBC to direct its purchasing. Similarly, the RBC guided consumer choice in a field of options for spiritual and personal self-development, but left consumers free to choose between various titles that best fit their particular needs and outlooks. Liberal religious reading practices had the effect of uprooting discourse from the contexts in which it developed and dispersing it across faith communities with different discourse norms and communicative practices. The titles of the books recommended, despite noticeable diversity in terms of trying to include faith perspectives from Catholicism, Judaism, and Catholicism, indicate a particular concern to create a rapprochement between religion and science.

In the first half of the twentieth century, the interlocking formal and informal institutions influenced by the RBC served as some of the governing mechanisms that greatly influenced reading habits of the mainline Protestant, Jewish, and Catholic middle class. The advisory nature of the RBC left great power in the hands of reading audiences, with consumers referring to RBC's guidance in order to inform their choices as to how to develop themselves spiritually and personally. The organizational structure of the RBC reflects the value of individual self-government, a hallmark of American Protestantism in a pluralist nation, to which liberal religious education contributed. Along these lines, Hedstrom writes that "the Religious Book Club serves as a reflection of the Protestant establishment's sense of itself, of its values, and of the role it imagined for itself in society."[7] It also served as an implement by which to fashion and reinforce religious liberalism, which featured open mindedness in the spirit of rational inquiry that was perhaps foremost in the value structure of liberal Protestantism in this era.

The spaces of open inquiry through the discussion of recommended texts that the RBC established were noteworthy because they encouraged the liberal Protestant embrace of psychology and Christian mysticism by placing this work on even footing with more familiar religious texts, implying an equivalency or at least the possibility of dialogue. The inner science of the mind and spirit became individually deployable technologies for healing and self-integration. Ideologies of personality and spirituality fused in this genre of liberal Protestant views on the person and world. This meant that many religious liberals imagined themselves as individuals with a particular personality and spiritual disposition, who could harmonize themselves with the created order in pursuit of self healing. Hedstrom says:

> Personality and spirituality became defining aspects of the middle-class American sense of self in the middle decades of the twentieth century. Liberal Protestants had first advanced psychological

[7] Hedstrom, *Rise of Liberal Religion*, 68.

> and mystical approaches to religious experience in the nineteenth century in an effort to craft a faith suitable for modern living.[8]

Confronted with the challenges of maintaining a rich context of significance for modern life, religious liberals admixed psychological and mystical views into a rationally tenable faith. This kind of faith prized personal fulfillment and robust spiritual, emotional, and physical health. It was made even more portable because it was fabricated through rationalizing discourses that made it more defensible in the public sphere. Drawing on Transcendentalism, American Romanticism, and an affinity for "Eastern Metaphysics," liberal religion integrated the pursuit of spiritual and scientific knowledge. Though they did so partially and incompletely, books embodying a religious liberal stance broadened the horizons of their audience by enabling open exchanges with persons immersed in alternative streams of spiritual practice.

Hedstrom's perspective indicates how these at first more marginal liberal religious views were dispersed throughout modern American culture so that they became much more widely influential in circles of well-educated elites and the rank and file of the middle class after the Second World War. The RBC played a leading role in this dispersal of religious liberalism. The RBC embodied religious liberalism's open and exploratory stance toward faiths other than mainline Protestantism, which meant that the RBC served as one of the social engines that drove the expanding influence of liberal religion in the US cultural formations of its era. The practices of reading groups cultivated a widespread appreciation for psychologized spirituality as an inclusive and eclectic practice of self-expression. Thus, the RBC recommended works written by Harry Emerson Fosdick, William James, Rufus Jones, and Emmet Fox, just to name a few of the liberalizing authors they favored. The project of spreading liberal religion was vital to statecraft as well as religious life. American leaders of the Second World War interpreted religious freedom as one of the most important values that distinguished the United States from totalitarian governments. In support of maximizing this political difference, the US government deployed religious reading groups as a particularly apt way to infuse American culture with norms of religious tolerance.

In line with this, and in an effort to counteract the ideological threat of Nazism, the FCC strengthened the National Conference of Christians and Jews (NCCJ), which was initially organized to dampen the nativist resurgence of the 1920s, in direct response to the passage of the National Origins Act of 1924. This legislation showed the high water mark of the xenophobic resistance to immigrant populations streaming into the US from Asia and South America in particular, which limited the influence of Asian religious practices until its repeal in 1965. The efforts of state and religious partners to counteract nativism and protect Jewish and Catholic communities

[8] Ibid., 168.

of faith also safeguarded American society for diverse expressions of liberal religion and spiritual seeking. These safeguards and norms of inclusivity also permitted Asian religion to gain greater influence by the 1950s. The wartime expansion of the NCCJ in response to Nazism built on previous institutions for the promotion of literacy as a nation-building project. This is why Religious Book Week (RBW), from 1943 to 1948, transitioned from an ecumenical affair rooted in Protestantism under the guidance of Fosdick and Cavert to an affair with a more balanced appreciation for Judaism, Catholicism, and Protestantism. The NCCJ built on earlier developments that issued from the RBCs. Finding a bedrock of reading practices and knowledge about mysticism and psychological sciences, RBW increasingly served as the basis for expanding exposure to other religious traditions besides Protestantism.[9] The institutionalization of reading groups in the early twentieth century formed one mechanism for the inculcation of liberal values through reading practices in a widespread reading public. Reading practices generated widely held values of receptivity to diverse religious views and practices, though they often did not encourage experience with practices other than reading and rational discussion.

The Cosmic Correspondences of Spiritual Seekers

Since the 1890s, seeker spirituality has placed a premium on embodied forms of religious experience paradigmatically accessed through religious practices that lead to altered forms of consciousness. Over the course of the twentieth century, spiritual seekers have showed considerable openness to "occult practices"[10] and investigated parallels they saw between spirituality and science, correspondences between the personal body and the cosmos. The fascination of the New England metaphysicals with Swami Vivekananda in the last decade of nineteenth century in New England is an important example of how spiritual seekers engaged with occult knowledge. In 1893, Vivekananda brought Neo-Vedanta to the United States by way of the World Parliament of Religions in Chicago. His success as an orator led to national tours and his eventual association with groups of metaphysicals in New England. He had a profound influence on William James, whom he met in the Cambridge parlor of spiritual seeker Sarah Bull, and contributed to James's views on the spiritual life of mystics.[11] This language of mysticism was broadly applied to the

---

[9] Ibid., 150.

[10] I am using this term in the way that Elizabeth de Michelis uses it in her explanation of the Neo-Vedanta taught by Swami Vivekananda. Western Occultism in her analysis references the late nineteenth and early twentieth century healing movement that attempts to achieve harmonization of the body with the cosmos through "somatic realignment" (2004, 116).

[11] Courtney Bender, *The New Metaphysicals: Spirituality and the American Religious Imagination* (Chicago: University of Chicago Press, 2010) 107-109; See also James Austin, *Zen Brain Horizons: Toward a Living Zen (*Cambridge: MIT Press, 2016), 65-70.

engagements of spiritual seekers with various East and South Asian religions. It bled across traditions, and key Buddhist modernizers like Anagarika Dharmapala described "the Message of the Buddha" as "the highest individualistic altruistic ethics, a philosophy of life built on psychological mysticism."[12] By dialoguing with mostly modernizing Asian writers like Dharmapala, Vivekananda, and D. T. Suzuki, communities of spiritual seekers accessed spirituality and Asian religious systems like Vedanta, Zen, and Theravada.[13]

Historian Elizabeth De Michelis discusses the importance of occult practices to modern postural yoga. For the purposes of her argument, she defines occult practices as forms of repeated collective behavior that confer intimate knowledge of spiritual-material resonances in the universe, which are believed to be hidden from the view of the uninitiated. The occult describes mystical and mysterious forms of practice that cultivate arcane knowing, which complements, and sometimes contradicts, rational ways of knowing. Interactions between Asian teachers and Western scientists hybridized religious-scientific discourse by integrating the notion of correspondences between the interior substance of identity (psychological substance) and the material extension of the cosmos. For instance, the collaboration of James and Vivekananda rendered yogic practices scientifically knowable by empirical study, establishing a historical precedent for the recent medicalization of meditation practices. This is one reason why American Zen neuroscientist James Austen, who has presented at UZC, thought to include an "Homage to William James" in his neurobiological discussion of Zen forms of awakening.[14] James foreshadowed Herbert Benson's exploration of contemplation as a means to relaxation by more than seventy years, writing in the "Gospel of Relaxation" about how bodily peacefulness signals similar pacific supernatural qualities.[15] A theory of correspondences enabled the body to signal the spiritual openness that relaxation indexed in bodily systems, and similar theories find expression in the ecological versions of American Zen that Halifax espouses. Gradual disentanglement from Protestant practices of narrating personal conversion experiences, reading the scriptures, private prayer, diary writing and Sabbath observance, distinguished seeker spirituality from institutional religion over the course of the first half of the twentieth century.[16]

---

[12] Donald Lopez Jr., *Buddhism and Science: A Guide for the Perplexed* (Chicago: Chicago University Press, 2008), 15.

[13] Lopez, *Buddhism and Science;* Richard Hughes Seager, *Buddhism in America* (New York: Columbia University Press, 2000); Leigh Eric Schmidt, *Restless Souls: The Making of American Spirituality* (San Francisco: Harper San Francisco, 2005).

[14] Austin, *Zen-Brain Horizons*, 65-70.

[15] Bender, *New Metaphysicals*, 109; See also Herbert Benson, *The Relaxation Response* (New York: William Morrow Paperbacks, 1975) for an early treatment of the physiological sequelae of the calm and relaxation induced by spiritual practices.

[16] Schmidt, *Restless Souls*, 18.

This particular hybrid form, that theorizes the connection between yoga-induced organic relaxation and a harmonious universe, assumes the presence of religious liberalism, because religious liberals took an open stance toward other faith traditions and modern scientific discourses that permitted the promiscuous blending of philosophical and theoretical outlooks. The common ground in religious liberal approaches was an attitude of acceptance toward human diversity and the breadth of human experience. In Leigh Eric Schmidt's analysis, religious liberalism indexed a complex aggregation of elements that was present in varying degrees amongst particular communities of religious liberals: 1) personal mystical experience; 2) the value of silence; 3) immanence of transcendent being; 4) appreciation for diversity; 5) ethical pursuit and social justice; and 6) creative self-expression. Influenced by German Romanticism, Transcendentalism, Universal Religion, and New Spirituality, religious liberalism featured these elements, and they continue to find expression in UZC's form of American Zen. As the movement towards more freedom of self-expression in worded and embodied modes characterized this movement, Schmidt finds the label liberal religion particularly apt. As the fringe element of religious liberalism, the seekers Schmidt discusses traversed an everyday topography that atheistic secularism viewed as disenchanted, but they saw as mystically inspired. What is distinctive about these spiritual seekers in comparison with liberal Protestants is that their exploration of non-Christian practices led them into new hybrid constellations of religious and spiritual practices that no longer found common ground in Christian theology, worship, or community belonging. Schmidt interprets James's use of the category of mysticism in *Varieties of Religious Experience* as a particularly meaningful reflection and legitimation of the authentic religiosity of spiritual seekers. He points to the popularity of the view James first espoused at the Gifford Lectures on natural theology between 1901 and 1902 as proof of the widespread appeal of contemplative practices of mystical spirituality.[17]

While seekers did engage in deep exploration of contemplation, they nonetheless arrived at their initial understandings about mysticism or the correspondences between human bodies and the cosmos through the religious reading practices that allowed a wide array of ideas about religion and spirituality to permeate communities of religious liberals. Within the totality of this social base, it was reading practices conjoined with an attitude of openness and receptivity to non-Christian and non-Western sources that were necessary conditions for the social constitution of religious liberalism broadly and seeker spirituality in particular. Just before the turn of the twentieth century, spiritual seekers like Sara Bull and Sarah Farmer valued the ability to harvest the fruits of various traditional religious systems. Both women played a formative role in drawing together spiritual seekers and religious adepts from Asia. Bull was one of the principal people behind Vivekananda's period of teaching in Cambridge, while Farmer organized the community

[17] See De Michelis, *History Modern Yoga*, 171-173; and Bender, *New Metaphysicals*, 107-109, as accompanying narratives to Schmidt's account of Vivekananda's influence on James.

of spiritual seekers in Greenacre, Maine that hosted Dharmapala among others. As both of these communities show, for many seekers of this era, textual studies of various religions inexorably tended to move beyond mere intellectual knowledge into forms of alternative spiritual practice.[18] From the basis of cognitive exploration and the accrual of knowledge about other religions, spiritual seekers began to experiment with mysticism, fashioning a cosmopolitan spirituality that hybridized new modes of spiritual practice. This trend of exploring "Eastern Metaphysical" thought began with the Transcendentalists in the 1820s, but it became much more widely diffused in educated circles in the first half of the twentieth century. At the beginning of the twentieth century, exploration of the "Metaphysical East" moved beyond religious reading and into contemplative modes of self-cultivation. By the 1960s, a sizable countercultural spirituality coalesced, which was almost entirely distinct from liberal Protestantism, though both shared a similar historical connection to liberal reading practices. As Schmidt explains, "the creation of that cosmopolitan, sympathetic disposition fueled one innovation after another in American spirituality. It was a sine qua non of a seeker culture."[19]

Spiritual cosmopolitanism implies the generative qualities of a receptive stance that animated the broader community of religious liberals and spiritual seekers. It generates dialogue and mutual learning through an open stance and spiritual curiosity towards others. Spiritual curiosity points to Halifax's passion for knowing about the religious systems of the Dogone, Diné, or Huichol in intellectual and embodied ways. For her and other spiritual seekers, knowledge of religious traditions that do not belong to the history or heritage of Western Europe often eventually parlayed into more generalized engagement in alternative religious practices such as *zazen* or Huichol initiation ceremonies. In his historical treatment of seeker spirituality, Schmidt pays particularly close attention to the rise of contemplative practices, documenting the emergence of Buddhist meditation as a new form of spiritual discipline. He notes that when spiritual seekers incorporated meditation practices into religious liberalism, they uncovered new ways to promote mind-body healing, which was an area of interest amongst religious liberals who were attracted to New Thought and Mind Cure. It may be true that the counterculture intensified spiritual seekers' exploration of contemplative practices originating in Vedanta and Buddhism, but the historical precedent dates back to the final decade of the nineteenth century. Therefore Schmidt's narrative culminates in a finely-grained historical analysis of Sarah Farmer's Greenacre community, established in Eliot, Maine in 1894.[20] For similar reasons, Courtney Bender explores narratives

---

[18] Here I am referring to forms of spiritual practice outside of the core spiritual practices central to liberal Protestantism, such as worded and improvised prayer, scripture reading, journaling, narrating conversion experiences, etc.

[19] Schmidt, *Restless Souls*, 25.

[20] Ibid., 120.

of New England metaphysicals as the historical foundation for late modern metaphysical spirituality she found in her fieldwork in Boston in the early 2000s.[21] These experiments in interfaith dialogue organized in New England just before the turn of the twentieth century had tremendous influence in the spiritualized psychological perspectives of liberal religion. In this period, seeker spirituality moved decisively beyond Protestant religiosity, and UZC is in striking continuity with these earlier projects. It integrates seeker spirituality with a strong commitment to Zen disciplines for the self-cultivation of wisdom and compassion.

A strong commitment to Zen was not possible in the seeker spirituality of the early twentieth century because the translation work of writers such as D. T. Suzuki, Alan Watts, and Paul Carus had not made Zen accessible to a broader audience in the seeker movement. While the trend of experimenting with meditation practices grew out of this particular moment in time, it took on greater social force by the 1950s and 1960s. Remembering the history of meditation's influence in seeker spirituality, Leigh Schmidt draws attention to the fact that the science of self-integration's reliance on meditation as the generative force behind the strengthening of the mind is not altogether novel.

> Meditation became a critical practice of self-integration in a culture in which the problem of divided selves and a unified personal identity had become, as William James observed, "the most puzzling puzzle with which psychology has to deal." The serial qualities of the self, the wholesale conversions of the twice born, and the irregular streams of human consciousness fascinated James, and he was far from alone in seeing the modern self as protean, fragmented, and discontinuous.[22]

Schmidt interprets meditation as an ideal complement to reading practices and interfaith discussion and debate in the splintering diversity of modern identity, which he traces back to the history of spiritual seekers more than a hundred years ago. Yet it is altogether misleading to insist that an emphasis on meditation in the science of the mind at the beginning of the twentieth century was anything more than a marginal emergence of seeker spirituality before the counterculture era. It was only as Buddhist meditation and yogic practices gained acceptance in the countercultural movement that contemplative practices of various sorts began to become popular therapeutic complements to psychological theories of integration.

---

[21] Bender, *New Metaphysicals*, 2-5.

[22] Schmidt, *Restless Souls*, 120-121.

Expressivism in American Zen

The Zen that emerges from these historical trends, Americanized by writers who emphasized the psychological aspects of Zen, tends to endless narrative expression. This type of Zen gives voice to the *dharma* in the language of self-expression that it then deigns to let go, so that it can dissolve and fall into oblivion, in preparation for a novel expression to emerge. Zen meditation practices provide the discipline by which the Zen student's mind is prepared for the self-spun narratives of expansive selfhood. It is likewise the discipline which prepares the meditator for the dissolution of these narrative self-expressions. American Zen Expressivism arose forcefully in the context of 1950s and 1960s, when several philosophical and social trends came together in communities of religious liberal and spiritual seeker alike. American Zen Expressivism is a particular form of a wider trend in religious communities that recognizes two distinct levels of human experience in relation to the social world, conventional self processes that constitute the self as a composite of social roles and the essential self processes that frame the inner self as the mysterious source of authentic action. Both dimensions of self-construction are enmeshed with each other and difficult to disambiguate. In his historical analysis of pastoral care, historian E. Brooks Holifield writes about concepts of the self in psychology's humanistic turn: "close to the heart of the therapeutic ethic was the familiar distinction between the conventional public self and the true inner self."[23]

This view of the self as an entity containing mysterious inner depths is continuous with Romantic views of the self that Charles Taylor traces to Johann Herder and his followers.[24] Taylor describes the Romantic construal of the self as heir to hidden "inner depths" and their endless articulation in webs of meaning. In this way of thinking, biographical narrative is the means by which one can understand oneself and others, shedding light on what is at stake for the self-expressing agent. Yet narrative can never entirely fathom the self and its inexhaustible depths. Taylor names this historical moment of common awareness about intensified self-creation that came about in the Romantic period "the expressivist turn."[25] In the expressive manifestations of one's inner depths, the human being fulfills herself in the process of articulating and refining her consciousness. Processes of self-articulation and the refinement of personal views are reciprocal and interdependent, unfurling in close interpersonal relationships as one engages in a process of be-

---

[23] E. Brooks Holifield, *A History of Pastoral Care in America* (Nashville: Abingdon, 1983), 320.

[24] Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge: Harvard University Press, 1989), 368-390; Charles Taylor, *The Ethics of Authenticity* (Cambridge: Harvard University Press, 1991), 61-63. See also David McMahan, *The Making of Buddhist Modernism* (Oxford, New York: Oxford University Press, 2008), 11.

[25] Taylor, *Sources of the Self*, 368-390.

coming alongside one's most significant others. The expressive self comes to know what it holds dear, what has a stake for it, or what it cares about in dialogue with other near selves. In this view of the self, the "notion that each one of us has an original way of being human entails that each of us has to discover what it is to be ourselves."[26] This turn toward expression of the meaning of one's life in narrative forms undergirds the spiritual care of modern chaplaincy, but it is also formative for the modernization of forms of American Buddhism. David McMahan indicates how Taylor's views on selfhood describe a social field ripe for modernized, psychologized, and de-traditionalized forms of Buddhist practice, because expressive narration highlights the uniqueness of the self in a interrelated community of selves.[27] Expressive spirituality has especially maintained its social force in instances when liberal religious subjects reinterpreted religious traditions and values in the light of reason and scientific knowledge.

This notion of the "power of expressive self-articulation" holds that the unique person, with all her mysteries and proclivities, is more valuable than a social role. As such, it "intensifies the sense of inwardness" and undermines "disengaged rational control."[28] In this model of being, the self is as an ongoing process of becoming, produced through self-expressive speech, and personhood is couched in linguistic forms. These ways of speaking about the self reflect a person's hidden mysterious depths, maintaining that people contain an essential element of the unknown and unknowable. Because self-expression is located in the individual, social institutions can be construed as little more than hierarchies to socially control an inner nature best left free. Expressivism bred a "certain distrust of 'analytic rationality' and 'technical reason' that manipulate people for bureaucratic ends."[29] The language of "freedom, openness, honesty, tolerance, sensitivity, and self-realization"[30] permeated cultural norms of authentic fulfillment of one's self-articulated personhood. This is why in the 1960s and 1970s institutions of moral reform like the asylum or prison came under intense attack from the progressive elements of society, which fell under the sway of "disenchantment with the rehabilitative ideal."[31] This meant conceiving of psychotherapy as a quest for freedom that empowered persons to resist the coercion of institutional settings. Alongside psychotherapists, clinical chaplains offered therapeutic services that

---

[26] Taylor 1991, 61. In a way that shows his suspicion of self-expression and the influence of Friedrich Nietzsche and Michel Foucault's genealogical method in his work, Nikolas Rose's take on this is that powerful subjects do not so much discover the self as invent it. See Nikolas Rose, *Inventing Our Selves: Psychology, Power, and Personhood* (Cambridge: Cambridge University Press, 1998).

[27] McMahan, *Making Buddhist Modernism*, 9-14.

[28] Taylor, *Sources of the Self*, 390.

[29] Holifield, *History of Pastoral Care*, 311.

[30] Ibid.

[31] Stanley Cohen, *Visions of Social Control* (Cambridge: Polity Press, 1985), 4.

encouraged patients to realize themselves through creative projects that made their interiority visible, articulable, and storied. Clinical chaplains who practiced spiritual care believed it beneficial to "restrict intervention in the name of liberty,"[32] calling on patients to examine and interpret their own behaviors in order to orient themselves. The clinical chaplain has become one of the many helping professionals in these counterculture era experiments "to test the minimum limits for the exercise of state power in order to enhance autonomy."[33] Personal autonomy and self-expressive narration were at the heart of the social movement embodied in interpersonal therapeutic practices, clinical pastoral care in hospital settings among them, to free the creative powers of the human person from the constraints of social institutions that were viewed as oppressive.

This notion of self-expression as the locus of spiritual meaning making held great sway in clinical pastoral education from its very beginnings in the mid-1920s. The paradigmatic self-articulating clinical chaplain who gives spiritual care to a self-articulating patient is formed in the image of spiritual psychologies, tells stories about herself that cast her as an altruistic person, and offers compassionate care in a secular institution. She elicits stories from the patients she visits, drawing patients into linguistic representations about their inner experience. From my interviews with over thirty Buddhist, Christian, and Jewish chaplains practicing in varied clinical institutions, I would say that this notion of persons as self-articulating, meaning-making creatures continues to be normative in late modern spiritual care. The personal and group educational practices of CPE continue to embody forms of textuality that represent the identity of the chaplain as an ongoing process of becoming, which is couched in language. As I mentioned in the first chapter, chaplain residents at Baptist Health render their experience in textual forms by writing weekly reflections, presenting cases (verbatims), integrating a statement of personal theology, and writing a narrative and analytical self-evaluation in the course of the each unit of their CPE residency. The presentation of a verbatim is especially critical in the educational process, because a verbatim enacts the presentation and deconstruction of self-identity in narrative and analytical modes in real time among a presenting chaplain and her peers and supervisor. This activity reflects the social force of normative self-expressive articulation at play in processes of chaplain resident self-reflection and group dialogue. As one of the most central practices of CPE residen-

---

[32] Ibid., 129.

[33] Ibid.

cy, chaplain residents present a case (verbatim) to their peers roughly five times per unit of CPE, and these cases represent chaplain (and patient) identity as a "living human document."[34]

The presentation of a verbatim is a process by which chaplain residents reflect on and dialogue about their responsibility to patients, families, and other clinicians. While the supervisor has authority to redirect the interpersonal dynamics of participating chaplains, her interventions take into consideration the defined learning goals of the residents themselves and their shared experience in individual supervision. The dialogue unfolds as a process in which a chaplain resident's peers point at moments in the conversation when the presenting chaplain showed empathy and compassion to persons encountered in the clinical scene or failed to do so. In either case, as the cohort develops both knowledge of and intimacy with each other, the discussion begins to skillfully free chaplain residents from ingrained habits of avoiding emotional resonance with patient and family experience that mirrors, and therefore triggers, their own grief. The processes I have described are a form of "expressive-collaborative ethics" featuring moral reasoning that is "*analogical* and *narrative*" and expressly sensitive to a chaplain's unique personal gifts, memories, and life experiences.[35] American Zen chaplaincy is beholden to this paradigm but changes it in a way that accelerates, through mindfulness, the process by which a chaplain becomes more self-aware. Mindfulness gives a chaplain more flexibility in reworking her narrative self, because she loses her close identification with narrative and evaluative appraisals of selfhood. This is because once a chaplain begins to practice mindfulness in the context of group work, she begins to engage more actively and deliberately with emotional and cognitive experiences that trigger grief. She is repeatedly engaging with and letting go of her own patterns of sensations, images, feelings, and thoughts associated with grief, which decomposes previous patterns of avoidance.[36]

---

[34] This phrase is generally traced back to Anton Boisen. The most authoritative statement on the implications of this phrase for the practices of hermeneutics in chaplaincy is made by Charles Gerkin, *The Living Human Document: Re-Visioning Pastoral Counseling in a Hermeneutical Mode* (Nashville: Abingdon Press, 1984); See also the volume edited by Robert Dykstra, *Images of Pastoral Care: Classic Readings* (St. Louis: Chalice Press, 2005), 1-46, for a sustained dialogue about the importance of this metaphor in the history and contemporary practice of pastoral care.

[35] Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (New York and London: Routledge, 1998), 65 (her emphasis); as Walker would say, the dialogues between chaplain residents and their supervisors about the clinical encounters represented in verbatim reports are a moral practice that justifies, attributes, negotiates, and refines a chaplain's responsibility for spiritual care.

[36] David Vago and Dvid Silbersweig, "Self-Awareness, Self-Regulation, and Self-Transcendence (S-ART): A Framework for Understanding the Neurobiological Mechanisms of Mindfulness," *Frontiers in Human Neuroscience* 6 (2012): 23-24; Kirk Bingaman, "When Acceptance Is the Road to Growth and Healing: Incorporating the Third Wave of Cognitive Therapies Into Pastoral Care and Counseling," *Pastoral Psychology* 64 no. 5 (2015): 577.

Zen Expressivism and Expressive-Collaborative Chaplaincy Ethics

Halifax's maturation as a pastoral person manifests the influence of religious reading practices that exposed her to a wide array of spiritual and religious practices as she grew up in a liberal Protestant community. By the time she attended Tulane University, she was primed to engage in social justice efforts and seeker spirituality that led to her exploration of Zen. An accompanying broad philosophical underpinning of Halifax's upbringing was the Romantic notion of self-expressive personhood that places an emphasis on how unique persons come to know who they are through their own narrative products. For Halifax, self-expressive narration interacted with mindfulness practice in such a way that both contributed to the discovery of the true self emerging from the inexhaustible hidden depths of the person. This true self emerges from the mysterious interior of the person as contrasted with layered aspects of conventional selfhood constructed through a person's interactions in social institutions. The framework that contrasts the hidden interior self and the socially conventional exterior self aligns with the way that clinical pastoral education attempts to uncover a core pastoral identity in the inner experiences of a clinical chaplain as she encounters patients on the medical scene. Mindfulness practice subserves this process of self-discovery as a catalyst to the basic transformative process of chaplain-patient encounters, which cohorts of chaplains reflect on and dialogue about in an expressive-collaborative style of ethical practice.

The expressive-collaborative ethics of a community of chaplains training together in a residency program resembles the community of Zen chaplains training at UZC, except that their spiritual practices may and often do differ markedly from one chaplain to the next. In both cases, a chaplain's moral understanding and processes of identifying for whom she is responsible take a narrative and analogical hue as chaplains reflect on and discuss how and why they provide care for particular persons—patients, families, and other caregivers—in the medical setting. My own experience of this in a residency training program has revealed my unique sense of empathy and compassion for others as an embodied interpersonal practice that draws on my personal upbringing as middle-class, white, Protestant, mindfulness practitioner and sexual abuse survivor who was raised in a United Methodist community of faith by a mother with bipolar disorder and a father who approaches life primarily through reason. My particular story intersects with Halifax in a meaningful way, in that I have studied both her and many of her students in depth. To a degree I have integrated her form of American Zen with my own orientation as a Protestant chaplain who espouses the openness of liberal religion to other faith traditions. It is to Halifax that I now turn, to map out how she builds on her notion of the self-expressive extended self in order to medicalize and then neurobiologize mindfulness.

Chapter 3

The Exemplarity of Roshis

> Many successful interpretations of Buddhist modernism have a similar mixture of tradition and innovation, contemplation and social engagement, commercial entrepreneurship and cultural critique.
>
> —David McMahan, *Making of Buddhist Modernism*

In contemporary American Zen, Joan Halifax embodies what moral philosopher Margaret Urban Walker calls a "dominant identity."[1] Halifax was born to a family of means in Coral Gables in 1942.[2] She was raised as a liberal Protestant and spent her early life in a segregated community. An early childhood illness left her blind for two years and she was forced to rely on her inner resources to cope with her affliction. Her family hired a caretaker named Lilla, an African American woman with whom Halifax developed a lasting bond. She began her study of Zen in the 1960s through her engagement with the texts of Alan Watts and D. T. Suzuki.[3] She attended Tulane from 1960 until 1963, joining in the Civil Rights Movement. In an interview with Malka Drucker about her involvement in the Civil Rights Movement during her time at Tulane, Halifax said "it lead me to what I wanted to do with my life: I wanted to work for social justice with people outside of mainstream culture."[4] She studied anthropology with Alan Lomax

---

[1] Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (London and New York: Routledge, 1998), 148-150, 218-219. Walker states that someone who represents a cultural ideal too fully may in fact display a dominant identity, the "public face of a social world that its members recognize as theirs," which requires that the members of the social group collectively "attend to" and "ignore certain things in order for that identity to be performed and claimed by some" (149). The ongoing display requires the careful masking of features of life that cut against the dominant identity. Walker asserts that dominant identities are not so much sources of oppression, though they are clothed in forms of power that causes those who embody them to fail to recognize the experience of marginal persons. I believe that most Zen teachers could be criticized for getting caught in this dynamic of displaying dominant identities, Halifax no less than others.

[2] The biographic section that follows relies heavily on three sources: Richard Hughes Seager, *Buddhism in America* (New York: Columbia University Press, 2000), 252-253; Bernard Glassman, *Bearing Witness: A Zen Master's Lessons in Making Peace* (New York: Bell Tower Press, 1998); and Malka Drucker and Gay Block, *White Fire: A Portrait of Women Spiritual Leaders In America* (Woodstock, Vt: SkyLight Paths Pub, 2003), 161-168.

[3] See David McMahan, *The Making of Buddhist Modernism* (Oxford, New York, 2008), 31-33. I see obvious parallels between Halifax and the character he sketches in "An American Dharma Teacher."

[4] Drucker and Block, *White Fire*, 162.

at Columbia University in the 1960s, and graduated in 1973 with a doctoral degree from Columbia in medical anthropology. She traveled to Mali to study the Dogon people, as well as to Tibet. She formally took refuge in the three jewels (*buddha*, *dharma*, *sangha*) in the Kwan Um school of Zen in 1966 after meeting and entering into a formal relationship with its Korean founder, Seung Sahn. She married Stanislaw Grof, a Czech psychiatrist in the mid-1970s, and with him explored the use of LSD in therapy for terminal cancer patients. Since the 1970s, Halifax has shown a consistent appreciation for the cross-cultural study of spiritual healers. Her *Shamanic Voices*, published in 1979, displays this cross-cultural reading of shamans as archetypes that can inform the practice of contemporary healers in the United States.

Halifax received ordination from the Kwan Um school in 1976 and continued to develop her practice in that tradition until she met Thich Nhat Hanh at Plum Village, France in the mid-1980s. She received ordination in Tiep Hien (The Order of Interbeing) in 1990, the same year that she founded Upaya, in Santa Fe, New Mexico. Within four years, Halifax had focused the work done at Upaya on providing "spiritual counseling to the terminally ill."[5] Her publication of *The Fruitful Darkness* in 1993 introduced a view of American Zen that combined ecological understandings of human selfhood with shamanism and Zen discourses on death and dying. In the late 1990s, Halifax formed a strong bond with Bernie Glassman and collaborated closely with him when he and his wife, Sandra Jishu Holmes, began the Zen Peacemaker Order (ZPO). Through her connection with Glassman, she became a teacher in the Soto Zen tradition and Upaya became "one of the teaching paths in the ZPO."[6] Upaya changed its name in the late 1990s to Upaya Peace Institute, and later to the Upaya Institute and Zen Center (UZC). In 2008, she published *Being with Dying* which integrates Zen approaches to palliative care, psychology, and neuroscience. *Being with Dying* cemented Halifax's reputation as a leading expert in Zen approaches to contemplative palliative care. By the end of the first decade of the new millennium, Halifax and UZC were widely recognized as influential voices in the discussion of spirituality's place in palliative care. Accompanying voices in Soto Zen, like Koshin Palley Ellison at the New York Zen Center for Contemplative Care (NYZCCC) share a basic understanding of Zen practice as compatible with spiritual caregiving in late modern biomedical institutions.[7] What is distinctive about Halifax is her readiness to adapt cutting edge scientific discourses, such as contemplative

---

[5] Richard Hughes Seager, *Buddhism in America*, 252. See also Joan Halifax, "Being with Dying: Contemplative Care of Dying People" (unpublished talk transcribed by Shelly Haley given at the University of Virginia Medical Center on October 21, 1998), https://www.upaya.org/dox/Being_Dying.pdf.

[6] Seager, *Buddhism in America*, 252.

[7] Koshin Paley Ellison and Matt Weingast, eds., *Awake at the Bedside: Contemplative Teachings on Palliative and End-of-Life Care* (Boston: Wisdom Publications, 2016).

neuroscience and neurobiology, which is a central trend in her most recent publications, especially *Standing at the Edge*, published in 2018.

Whereas Zen practitioners have long shown an affinity for literature and philosophy, many of the figures that participate so actively at UZC also identify as scientists who study the intersection of consciousness and biological structure in human experience. In fact, many luminaries in neuroscience approaches to contemplative practices have participated in retreats at UZC. Richard Davidson, James Austin, and Daniel Siegel have all taught at UZC in the last two decades. Through this work of organizing retreats that draw together neuroscientists and Zen teachers, Halifax is integrating Zen and neuroscience discourses in such a way that she is reinventing American Zen traditions and medicalizing Zen practices (including *zazen* and mindfulness practices). The teachings that Halifax gives combine American Zen approaches to experience, while they at the same time shift the framing discourses for Zen practices in the direction of the explicit mapping, furnishing rationalized, scientific descriptions of neural correlates of consciousness that correspond to subjective reports of spiritual awakening. The shift in Halifax's discourse responds to three kinds of needs in modern medicine. First, it provides a form of medicalized spiritual care that caregivers can apply in hospitals that is emptied of doctrinal commitments to deities. Second, it fits well with hospital needs for a ministry of presence that makes no commitment to theologizing doctrines. Third, it places an emphasis on the natural sacrality of space, at once naturalizing the sacredness of space while arguing that this space is absolutely ordinary. By meeting these needs, Halifax's American Zen has gained entrée into the world of clinical chaplaincy and the rise of UZC is possible because of the way its voice crosses over from the retreat center into the medical context. In this work of reinventing American Zen in a medicalizing key, the particular geographic and social context of UZC, at the crossroads of academy, hospital, and retreat center in the United States, is particularly important in the development of a medicalized American Zen. Perhaps no other country besides the United States boasts the density of neuroscience researchers, a robustly psychologized Zen, and medical systems beset with the problems of dehumanized medical care.

The Rise of Zen Buddhist Chaplaincy in America

In 1990, Joan Halifax founded what would become UZC, concretizing an ongoing shift in American Zen and particularly in its pragmatic engagement with medical care. UZC has become an essential site for dialogue between practicing Buddhists, research scientists, and medical caregivers, including through its Chaplaincy Training Program. In this chapter, I will detail three central trends in American Zen over the past half-century: the incorporation of ecological awareness, the focus on medicine and the medical setting as a site of practice, and the use of neurobiological

frameworks to explain and legitimize Zen practices, particularly mindfulness and compassion training. I use three of Halifax's books as the frame: *The Fruitful Darkness*, *Being with Dying*, and *Standing at the Edge*. Through these works, and an examination of Halifax's mentors, collaborators, and students, I will construct an argument about both how and why Halifax was a central part of the reinvention of American Zen as a discipline that appeals to a specialized medical audience. This medical audience is comprised of chaplains, doctors, nurses, and other therapists in search for a method of value construction that fits with the preference for empirical approaches to human experience that are normative in clinical settings. A wide variety of chaplains and other medical caregivers, many who are still grounded in religious traditions besides Zen Buddhism, are attracted to UZC because at UZC they find powerful tools for skillfully enacting compassionate care.

Under Halifax's leadership, UZC's training for chaplains, nurses, and doctors has enabled socially engaged Buddhism to extend into the field of clinical chaplaincy in an organized and purposeful way. In the 1980s, Bernie Glassman made it acceptable to practice *zazen* in the streets, relaxing the boundary between secular and religious domains. This is the type of Zen Buddhist community in which Halifax matured as a Zen teacher and a spiritual leader, since she belonged to Thich Nhat Hanh's Order of Interbeing, another socially engaged Buddhist order, immediately before joining Glassman's ZPO. The relaxation of the boundary between secular work and religious path facilitated Halifax's combination of the two in her clinical caregiving trainings. I trace UZC's founding in 1990 to three interwoven themes of Halifax's life: 1) her social activist roots in the 1960s and 1970s; 2) her training as a medical anthropologist, and 3) her four decades of personal experiences with giving care to persons dying in clinical settings. Halifax benefited from having access to the *dharma* of "wisdom-compassion"[8] as taught by Taizan Maezumi, transmitted through Glassman. Following Nhat Hanh, she has combined compassion with an emphasis on mindfulness, translating Nhat Hanh's mindfulness and compassion teachings into trainings for healthcare providers. Her personal connections with teachers, academic training, and experience in clinical settings have given her an ideal position at the crossroads of medicine and religion. Halifax has translated the *dharma* into medical idioms and enabled the transmission of American Zen teachings to a community of interested medical caregivers, who regularly cross boundaries between secular and religious institutions. Accordingly, Halifax's version of *dharma* incorporates neurobiological discourse to scaffold her teachings on the processes of personal and group transformation.

In the past three decades, Halifax has published a series of three books. These books express the development of her views since founding UZC, and I will analyze them in depth in order to

---

[8] Robert Aitken, "Forward," in *On Zen Practice: Body, Breath, and Mind*, ed. Taizan Maezumi and Bernard Glassman (Boston: Wisdom Publications, 2002), xvii.

trace the trajectory of her form of American Zen *dharma* and to establish the framework within which this form of Zen has been deployed in the practice of chaplaincy, particularly among clinical chaplains. Her literary corpus manifests a trend of incorporating scientific discourses that begin with spiritual psychological frameworks, move on to ecological frameworks, and end with a forceful hybridization of American Zen and the neuroscience of compassion. These books narrate Halifax's turn toward medicalizing mindfulness and *zazen* through an ongoing dialogue with neuroscience. Medicalizing mindfulness and *zazen* responds to a self-identified need in clinical institutions for the development of caregivers who embody – in the truly corporeal sense – spiritual and religious values, such as empathy, compassion, and equanimity. As I will explore in greater detail in the subsequent chapters, graduates of the UZC program translate a suite of physically enacted spiritual practices, including mindfulness meditation, letting go, bearing witness, interpersonal attunement, and pausing, into their practices of caring for patients, families, caregivers, and staff. These clinical chaplains can then enter into dialogue with patients desirous of spiritual support and medical professionals looking for practices that have qualitatively and quantitatively documentable effects.

A line of critique is apropos to mention here. Critical voices in neuroscience and psychology have asserted that the research on the application of mindfulness to clinical and therapeutic problems is not sufficiently rigorous and does not account for nuances in individual neurological structure. For example, psychologists Miguel Farias and Catherine Wikholm urge caution in the use of mindfulness as a therapeutic technique because of the "lack of clear evidence of its benefits" and the tendency of psychotherapists to apply it without an appreciation for the individual uniqueness of patients.[9] Neuroscience researchers Jared Lindhal and colleagues report that more than four fifths of meditators in the West using various modalities of contemplation (88%) reported adverse effects like fear at feeling less bounded in personal identity as a result of meditation. These adverse effects entered into the daily lives of research subjects and caused disruption beyond the formal meditative session. Almost three fourths (73%) of those adversely effected indicated moderate to severe impairment with 17% reporting persistent suicidal ideation and 17% requiring inpatient hospitalization.[10] Similarly, Madhav Goyal and colleagues concluded that meditation does not outperform other forms of therapeutic intervention (such as physical ex-

[9] Miguel Farias and Catherine Wikholm, "Has the Science of Mindfulness Lost Its Mind?" *BJPsych Bulletin* 40 no. 6 (2016): 329, doi:10.1192/pb.bp.116.053686. Farias ad Wikholm conclude: "Mindfulness has its place in therapy, as one of many techniques available to a trained clinician. However, we need to understand who it benefits and when, its merits and limitations" (331).

[10] Jared Lindhal et al., "The Varieties of Contemplative Experience: A Mixed-Methods Study of Meditation-Related Challenges in Western Buddhists," *Plos One* 12 no. 5 (2017): 1-38.

ercise or relaxation) as a treatment for pain, anxiety, and depression.[11] In another study, Keiran Fox and his colleagues report that almost none of the seventy-six functional neuroscience publications on the effects of meditation practices that they reviewed in 2016 reported a null effect.[12] They believe that this means that neuroscience publications are biased toward reporting only positive results in terms of the activation and deactivation of brain circuits as a result of meditation. The science claims to know more than it does; it has puffed up displays of its ability to map interiority as such. And sometimes meditation can do harm. This body of critical research demonstrates that mindfulness needs to be contextualized within community and therapeutic relationships, has more limited benefits than neuroscience studies indicate, and should not be viewed by those in the helping professions as panacea to be applied universally to mental health problems or processes of spiritual and moral self-cultivation.

The Extended Self Discovered in the Fruitful Darkness

In 1993, Halifax published *The Fruitful Darkness*, which is an integrative framework for finding coherence between the viewpoints of deep ecology, Buddhism, and shamanism. "All three of these practices," Halifax writes, "are based on the experience of engagement and the mystery of participation."[13] The practices of deep ecology, Buddhism, and shamanism all center on the relationship of the self to its surrounding environment as experienced through the body. "Rooted in the practice and art of compassion, they move from speculation to revelation through the body of actual experience."[14] Thus Halifax relates:

> As a Western woman, whatever I have learned about the nature of the self, both the local and the extended self, has been by going inward and down into the fruitful darkness, the darkness of culture, the darkness of psyche, the darkness of nature. The most important secrets seem always to hide in the shadows.[15]

Halifax's concept of the fruitful darkness brings together cultural, psychological, and ecological resources for healing at the boundary of the knowing mind. In dialogue with Buddhist ecologist

---

[11] Madhav Goyal et al., "Meditation Programs for Psychological Stress and Wellbeing: A Systematic Review and Meta-analysis," *JAMA Internal Medicine* 174 no. 3 (2014): 357-368.

[12] Kieran Fox et al., "Review Article: Functional Neuroanatomy of Meditation: A Review and Meta-Analysis of 78 Functional Neuroimaging Investigations." *Neuroscience and Biobehavioral Reviews* 65 (2016): 223.

[13] Joan Halifax, *The Fruitful Darkness: A Journey Through Buddhist and Tribal Wisdom* (New York: Grove Press, 1993), xxx.

[14] Ibid.

[15] Ibid., 4-5.

Joanna Macy, Halifax sees the extended self that expands into the shadows as a neural node within a wider net. "The extended self brings into play wider resources" Macy wrote, "like a nerve cell in a neural net opening to the charge of other neurons. With this extension comes a sense of buoyancy and resilience."[16] In this project of Buddhist eco-psychology, Halifax and Macy do not confine themselves to biologically determined interiority limited by the skin. They argue that establishing a resilient self requires the integration of cultural, psychological, and natural elements that extend beyond one's biological organism.

Drawing on religious reading practices to explore shamanism across a variety of cultures, Halifax takes a deep dive into Buddhist approaches to ecological science, systems theory, and her own explorations of Zen. She interlinks these frameworks into a trifold correspondence in which ecological, shamanic, and Zen perspectives on the sentience of all beings and aspects of reality mirror each other. For instance, she says that "from the ecological, Buddhist, and shamanic perspective, sentience is part of the greater picture of the living universe."[17] When she remarks on these correspondences, Halifax articulates the view that all beings have some form of sentience native to their experience. This notion extends sentience beyond the animal kingdom. She continues,"I am not totally convinced that there is not in fact a kind of awareness in the mineral and plant world," that is, rocks know in rock sentience, and plants know in plant sentience. Halifax makes this statement, though she is unable to discount the effect of her desire to see the world this way on her perception as such.[18] The viewpoint Halifax offers, which re-enchants the natural order, is not out of keeping with other Buddhist lineage heads and meditation masters, Buddhist studies scholars, social scientists, or ecologists inspired by or sympathetic to American Zen, such as Arne Naess and Fritjof Capra.[19] In her landmark articulation of Buddhist ecology, "World as Lover, World as Self," Macy proposes a similar novel view of personal-cosmic correspondences: "For when you see the world as lover, every being, every phenomenon, can become—if you have a clever, appreciative eye—an expression of that ongoing, erotic impulse."[20] Both Halifax and Macy argue in nuanced ways that the environing world offers a caregiver endless doors into compassionate identification with the pain and suffering of countless others.

---

[16] Joanna Macy, *World as Lover, World as Self: Courage for Global Justice and Ecological Renewal* (Berkeley: Parallax Press, 2007), 157.

[17] Halifax, *Fruitful Darkness*, 174; See parallels in McMahan, *Making of Buddhist Modernism*, 32.

[18] Halifax, *Fruitful Darkness*, 174-175.

[19] McMahan, *Making of Buddhist Modernism*, 169-170; Donald S. Lopez Jr., *Buddhism and Science: A Guide for the Perplexed* (Chicago: Chicago University Press, 2008), 25-28.

[20] Joanna Macy, "World as Lover, World as Self," in *Engaged Buddhist Reader*, ed. Arnold Kotler (Berkeley: Parallax Press, 1996), 158; see also Macy, *World as Lover*, 17-29.

Halifax's writings on Zen ecology spiritualize the universe, making space sacred and representing human beings as integrated into a spiritual order that encompasses human becoming. Her reasoning manifests "the importance to contemporary Buddhism in the West of the Weberian dynamics of disenchantment/reenchantment of the world,"[21] which sees the atomization of the modern ego "as an illusory product of the modern age"[22] responsible for many of the ecological problems of the contemporary world economy. In stereo, Halifax and Macy write about how the sentience of the world is wooing human beings sensitized through *zazen* (or mindfulness) into subtler forms of familiarity with its ways, which opens the spiritual seeker to ongoing sensuous playfulness. However full of rapture, the pleasure of seeing the world as a lover is only preliminary to seeing the world as self. That is, the extended self becomes the expression of the world located in a particular human body—the holographic view of the system in the particular node. For it is when the extended self opens to what is taking place around it through its awareness that it regains a sense of wholeness. To this end, Macy echoes systems theorist Gregory Bateson, "mind itself is immanent in nature." Its presence extends "far beyond the tiny spans illumined by our conscious purposes."[23] In Zen ecology, the natural world reflects the sentience of mind, while mind reflects the sentience of the natural order. Shifting to a frame of reference that includes other beings, even non-human ones, as worthy of consideration does not, in Macy's way of seeing things, necessitate a loss of one's unique view. She writes, "to experience the world as an extended self and its story as our own extended story involves no surrender or eclipse of our individuality."[24] Thinking along similar lines, Halifax reframes the vows of the bodhisattva to

---

[21] McMahan, *Making of Buddhist* Modernism,172; Max Weber, *Protestant Ethic and the Spirit of Capitalism* trans. Talcott Parsons (London and New York: Routledge, 1992), 61 and 71; Max Weber, "Science as a Vocation," in *From Max Weber: Essays In Sociology* trans. Hans Heinrich Gerth, C. Wright Mills (Milton Park, Abingdon, Oxon, New York: Routledge, 2009), 148 and 155. In both these texts, Weber defines his seminal sociological views on the effect of rationalization in the disenchantment of the world. See also Gerth, Hans Henreich, C. Wright Mills, "Introduction: The Man and His Work," in *From Max Weber: Essays In Sociology* (Milton Park, Abingdon, Oxon, New York: Routledge, 2009), 51. In their introduction to his collected works, Gerth and Mills offer the useful gloss on Weber's theory of disenchantment "rationalization is thus measured negatively in terms of the degree to which magical elements of thought are displaced." That is, as the world is progressively disenchanted by rationalization, the explanation of events as magical disappears from ways of making significance in social life. For a description of similar viewpoints on the continued enchantment of the world amongst spiritual seekers in New England, see Courtney Bender, *The New Metaphysicals: Spirituality and the American Religious Imagination* (Chicago: University of Chicago Press, 2010), 184-189; for a similar narrative about Protestant enchantment, see Pamela E. Klassen, *Spirits of Protestantism: Medicine, Healing, and Liberal Christianity* (Berkeley: University of California Press, 2011), Chapter 1, Ebook Central.

[22] David McMahan, *Making of Buddhist Modernism*, 171.

[23] Joanna Macy, "World as Lover, World as Self," in *Engaged Buddhist Reader*, ed. Arnold Kotler (Berkeley: Parallax Press, 1996), 159. See McMahan, *Making of Buddhist Modernism*, 169 for an appreciation of Bateson's influence on Buddhist ecologists.

[24] Macy, "World as Lover," 160.

extend to all dimensions of the world. "I am sure that the vow of the bodhisattva does not exclude those who are not human," she says. "It is also clear that our identity is not limited to what is wrapped up in our own skins. This means that the human being is not the only being with rights" or its own form of uniqueness.[25]

Buddhist ecologists like Macy and Halifax have extended this polarity of the conventional self/true self into distinct forms of ecological criticism of modern individuality. In this way of thinking about modern disenchantment, the social constitution of a conventional self leads to the feeling of separation from the environment, which enables callousness toward the natural world and environmental degradation. As David McMahan remarks, the re-enchantment of the natural order is the essential intervention of modern Buddhist ecological thinking, which he links to Romanticism, a reinvention of the Buddhist teachings on dependent origination, and systems theory.[26] As McMahan says of Arne Naess's formulation: "Deep ecology asserts a symbiotic relationship between the individual and the environment in which each reciprocally constitutes the other."[27] In Macy's reasoning, the separation felt by the conventional self contrasts with the expansion of compassion for others felt by the extended self that integrates the human being with an awareness of and solidarity with the environment and the creatures that inhabit it. This distinction between the conventional self and extended self has continued to be a place where American Zen and Protestant teachers reinvent teachings by integrating processes of self-constitution in Christian and Buddhist forms of ecological spiritual care.[28] The basis of understanding selfhood in its webs of relationship is the expanded notion of self that ecological perspectives describe in scientific discourse. This concept of the extended self enables Zen chaplains to frame the self-expressive person that clinical chaplaincy features as its primary object with reference to various scales of relationship with other beings in community. A Zen clinical chaplain relates to her Zen community, her clinical community, her animal community, etc. All these various types and scales of relationship form the basis for processes of self-transformation that can be described in narrative forms that incorporate rationalizing scientific discourse.

In language influenced by Buddhist ecology and cross-cultural study, Halifax holds forth the view that all creation is sentient and therefore human communities have a responsibility to care for all the diverse beings in the world. The depths of the extended self, expressive in interrelationship with other sentient entities (animals, trees, rocks), become a portal to greater awareness

---

[25] Halifax, *Fruitful Darkness*, 176.

[26] McMahan, *Making of Buddhist Modernism*, 13 and 168-173.

[27] Ibid., 169.

[28] Besides Joanna Macy, *World as Lover*; and Halifax, *Fruitful Darkness*, see Howard Clinebell, *Ecotherapy: Healing Ourselves, Healing the Earth* (New York: Haworth, 1996) for a liberal Protestant version of ecological therapy.

of all the sentience of beings. The interconnection of sentient beings made available to the awareness of an extended self enhances the powers of feeling for and with others a chaplain encounters on the clinical scene. The empathy a chaplain feels when the knowing of the extended self becomes an integral feature of mind and heart supplies her with the emotional resonance, motivation to ease suffering, and interpersonal insight into the pain and sorrow of persons confronted with illness, mortality, and loss.

Embodied Values in the Presence of Death

In her next book *Being with Dying*, Halifax turns her focus to the importance of death and dying in Zen practice and late modern medical care. In this book, she offers the culmination of the wisdom that she has culled from working with dying patients over four decades.[29] Her writing on the subject followed her establishment of the Project on Being with Dying to train caregivers in contemplative end-of-life care in 1994.[30] In *Being with Dying*, Halifax establishes her reputation as a master meditation teacher for medical caregivers, teaching them how to incorporate the ordinary sacredness of Zen into medical institutions. She firmly roots the book's orientation in the Three Tenets that Glassman formulated for ZPO, beginning the book with a description of not-knowing, bearing witness, and compassionate action (for more on the Three Tenets, see Chapter 4).[31] Speaking about how mindfulness grounds a caregiver in the body and mind, she says:

> When we are learning to practice mindfulness—and even when we have been meditating for many years—we bring our concentration to that most intimate object, our breath. We abide in that intimacy. We then expand our concentration to include our body, learning to dwell in the oneness of the breath, mind, and body.[32]

Her view arranges mindfulness's three core elements—breath, mind, and body—in a slightly different order, but the basis of her teaching is grounded in the view of Maezumi. Maezumi similarly writes about how bringing the body into harmony through the posture of *zazen* stabilizes the breath. "As body and breath begin to settle down and no longer create disturbances for us," he instructs, "we find that the mind too is given the opportunity to settle into its own smooth and

---

[29] Glassman, *Bearing Witness*, 181.

[30] Joan Halifax, *Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death* (Boston: Shambala, 2008), Audible.

[31] Halifax, *Being with Dying*, xvii-xviii and 199.

[32] Ibid., 13.

natural functioning."[33] The meditating caregiver harmonizes body, breath, and mind in the retreat setting, which gives her an ability to intensely focus on whatever she finds in a clinical setting.

In *Being with Dying*, Halifax presents mindfulness as the key to cultivating the concentrated awareness necessary to synchronize body, speech, and mind.[34] Halifax reasons that this synchronization of her being gives a clinical caregiver more courage and resilience to face the challenges of clinical care or personal experience: the unraveling of a demented patient's mind, finding a lump in one's breast, the death of a loved one, etc. Instead of avoiding difficult and intractable circumstances, the mindful caregiver can bring her "full attention to the immediate situation, without adding anything extra."[35] She can embody an extended self that spiritualizes and sacralizes space without making such spiritualized sacred space extraordinary. In this work, mindfulness provides grounding in the body and stability of mind, so that clinical chaplains can skillfully encounter and compassionately respond to patients in deep distress over adverse life events. The commitment to practice *zazen*, like mindfulness, repeatedly means a commitment to "being present." It is to "practice being present,"[36] as Halifax says, to bear witness to any manner of human experience from the grief of a parent losing a beloved child to an untimely death to the confusion of an elderly man slowly losing his memory. The chaplain's mindfulness practice interiorizes the spaciousness in which to greet the confusion, anger, dismay, sorrow, and hopelessness that follows in the wake of suffering, illness, and death.

As hospital chaplaincy increasingly construes itself as a "ministry of presence,"[37] Zen Buddhist teachers make the argument that the contemplative practices on which modernized forms of Zen are founded enact ways of being that align with the requirements of medical caregivers. American Zen teachers claim that this is because meditation practices enable chaplains to be present and receptive to others. The kind of presence that Zen chaplains bring to their clinical engagements aligns with trends in hospital chaplaincy made explicit in Carl Rogers's "client-centered therapy," which focused on providing spiritual care that honored patient experiences as in-

---

[33] Taizan Maezumi, *On Zen Practice: Body, Breath, and Mind* (Boston: Wisdom Publications, 2002), 4.

[34] Halifax, *Being with Dying*, Chapter 2.

[35] Ibid., here Halifax succinctly describes bare attention in caregiving; see also Rick Hanson, *The Enlightened Brain: The Neuroscience of Awakening* (Boulder: Sounds True, 2014), Chapter 24, Audible.

[36] Halifax, *Being with Dying*, Chapter 2.

[37] Winnifred Sullivan, *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014); Wendy Cadge, *Paging God: Religion In the Halls of Medicine* (Chicago: University of Chicago Press, 2012). Both Sullivan and Cadge make this argument about how chaplaincy is extending its reach by providing services to patients who have no formal commitment to religious communities. The ministry of presence is the conceptual, theological warrant to Protestant clinical chaplains to engage in ministry with non-religious or spiritual-but-not-religious patients, families, or colleagues in the age of spirituality qua naturalized and universalized religion.

herently dignified.[38] As Susan Myers-Shirk writes, Roger's work culminated in the production of his client-centered approach and established patient autonomy or "personal choice" and "self-expression" as paramount goods in his ethical system, and concretized a "postwar liberal moral sensibility."[39] Zen provides chaplaincy a disciplined method to achieve presence that requires no formal theological commitments. The emphasis on formal and informal meditation practices enables Zen chaplains to place ontological commitments to the teachings about no-self, impermanence, and the truth of suffering in the background in order to foreground compassion in clinical care. Zen Buddhism encourages the practice of wise compassion based on the emptiness of identity as the paradigmatic way to respond to the suffering of a clinical world. Halifax has adapted this approach to the medical scene in a moment when interfaith chaplains, who were mostly Protestant, had already begun to keep doctrinal content in the background as they approached clinical work.

In her teaching of practices that enable caregivers to provide skillful spiritual care to patients, families, and other caregivers, Halifax eclectically incorporates any means that will serve to release natural reservoirs of compassion that she believes are inherent in all human beings. Halifax and other Zen teachers on whose legacy she builds have emphasized that *zazen* primes the mentality of not-knowing. For example, "I vow to penetrate the unknown," is one of the sixteen precepts taken by Zen Peacemakers.[40] To penetrate the unknown, does not mean that a peacemaker enters into the unknown in order to convert it into a space of knowledge. Rather it means to abide in a state of not having and not needing to have answers that precede experience and determine expectations. Not-knowing minimizes the habit of approaching experience through the outlays of the self's ways of evaluating the world. Not knowing thereby encourages minimal self-referencing.[41] To not-know means to "develop openness to seeing things as they are, the constant flow and interpenetration of life, free from expectation, boundary, and limit."[42] Abiding in the unknown is not really about rejecting knowledge. Letting go and abiding in not-knowing amounts rather to a skillful deployment of knowledge in the service of the situation. It means being very careful not to misapply the frameworks of any particular way of knowing to a situation that calls for another type of knowing or a response altogether different from knowing. Thus, Glassman said of not-knowing, "the practice at the Zen Peacemaker Order is one of letting go.

---

[38] Carl Rogers, *Client-Centered Therapy: Its Current Practice, Implications, and Theory* (London: Constable & Robinson, 2003). The book was first published in 1951.

[39] Susan Myers-Shirk, *Helping the Good Shepherd: Pastoral Counselors In a Psychotherapeutic Culture, 1925-1975* (Baltimore: Johns Hopkins University Press, 2009), 91-92.

[40] Glassman, *Bearing Witness*, 66-73.

[41] Hanson, *Enlightened Brain*, Chapter 24.

[42] Glassman, *Bearing Witness*, 68.

Not letting go of the things we know, but of our attachment to them."[43] Zen Peacemakers accumulate the resources of knowledge and skill, but as they engage with any social situation—with all its complexity of resources and problems—they enter into relationship from a place of not-knowing. They enter into interpersonal engagement with the actors in the social network in which they work with humble hearts, receptive to what they find, continuously working to let go of their judgments and prejudices. This forms the basic preparatory move of spiritual care as Halifax teaches it, clearing the space of the mind for bearing witness.

Being present to a suffering or dying person in the way that American Zen chaplains practice depends on the cultivation of mindful awareness of points of resistance in the chaplain. This way of serving the demented, sick, dying, or incarcerated person requires years of slow and steady self-cultivation in relationship with a religious community under the guidance of a teacher. In *Being with Dying*, Halifax describes her own struggle with her aversion to suffering and the insistent return of thoughts that evaluate situations. She narrates how, as she encounters these conditioned responses, she tirelessly lets go of evaluative reasoning and returns to serving the persons and contexts right in front of her.[44] When a Zen chaplain becomes aware of her attachments to knowledge, judgment, safety, and freedom (or anything else), this is the first step to letting go of them. The chaplain can only become aware of her clinging to safety or pleasure in the context of facing duress. When she lets go of attachment in order to ease the pain and suffering of other beings, she embodies the desire and activity of a bodhisattva. She transforms shared duress into the full embodiment of the bodhisattva's compassion. Mindfulness stabilizes the mind-body so that the chaplain, modeling her bodhisattva "archetypes,"[45] can clearly see how she is clinging to whatever pleases her about her experience. Halifax makes the argument that the Zen chaplain is equipped through such awareness with the power of choice, using suffering to honor what she values and cut away all other actions. As she becomes progressively more self-aware, the Zen chaplain can increasingly release her grip on her attachments in order to open herself to all the dimensions of her experience and find what Halifax describes as her extended self.

This reasoning about Zen chaplain maturation holds that the chaplain who has a firm grip on the perceptions of her extended self attenuates the attachments and self-protective instincts of her lodged in her. Mindfulness gives her a method by which to gradually open to the suffering of others without feeling overwhelmed. Teachers of mindfulness like Sharon Salzberg, who ground their practice in Theravada, suggest that regular practice enables caregivers to diminish self-protective behaviors that prevent them from serving others. As Salzberg explained in *Lovingkind-*

---

[43] Ibid., 72.

[44] Halifax, *Being with Dying*, Chapter 4.

[45] Ibid.

ness, mindfulness meditation practice generates a happiness that external circumstances cannot uproot. Salzberg said: "we must move from trying to control the uncontrollable cycles of pleasure and pain, and instead learn how to connect, to open, to love no matter what is happening."[46] According to this teaching, a certain dimension of a human being remains "inviolable"—unharmed in all circumstances: "this is the innate happiness of awareness."[47] Health and wholeness depend, in Salzberg's reckoning, on the "radical change of view" that begins in the interiority of person.[48] Any person is necessarily in relation to external phenomena, but those practicing lovingkindness learn how to receive in a loving embrace all their internal responses to external circumstances. Zen chaplains learning this modality of relating with themselves learn forms of self compassion and "experiential acceptance."[49] After receiving the phenomena of experience into the interior space of their awareness, lovingkindness meditators can begin work to transform themselves. What enables a radical change of view for a contemplative chaplain is how she relates to the conditions of clinical practice based on an affective and volitional change of her attitudinal stance. The process that governs this change of attitudinal stance is her engagement in formal Buddhist meditation practice in various forms. At first beginning with a practice that develops the power of the mind to concentrate such as mindfulness, the contemplative chaplain seamlessly moves into practices that engraft important values in her mind-body experience. For instance, she finds acceptance of self and other through lovingkindness (Sanskrit *maitri*; Pali *metta*), an unconditional tenderness for oneself and others. A clinical chaplain who abides in this *metta* mindstream has resources to provide compassionate and equanimous care that takes sympathetic joy in the flourishing of others or takes pains to free others from suffering.

Halifax has directly applied this teaching to the context of palliative care, generating a toolkit of contemplative resources for caregivers to use to attend to dying patients and their grieving families. In the chapter entitled "At Home in the Infinite," she shows how the four *brahma viharas* (boundless abodes)—compassion, equanimity, sympathetic joy, and lovingkindness—come alive in the context of giving care to dying persons. This chapter is representative of the structure of the entire book. It follows a fourfold pattern: 1) it begins with an exemplary story from scripture about the Buddha giving care; 2) it outlines a statement of Buddhist values; 3) it fleshes out these values with narratives that show why the value is "inherent to our basic nature;" and 4) it

---

[46] Sharon Salzberg, *Lovingkindness: the Revolutionary Art of Happiness* (Boston: Shambala, 1997), 12.

[47] Ibid., 13.

[48] Ibid., 17.

[49] Kirk Bingaman, "When Acceptance Is the Road to Growth and Healing: Incorporating the Third Wave of Cognitive Therapies Into Pastoral Care and Counseling," *Pastoral Psychology* 64 no. 5 (2015): 567-579.

ends with a guided meditation offering others blessings that embody the boundless abodes.[50] Because in her frame of reference they are an unconditional treasures, accessible to all human beings, Halifax defines the boundless abodes as the ideal means chaplains and caregivers can use to practice selfcare. The chapter begins with an exemplary story of the Buddha taking care of the monk Tissa who fell ill. The faithful monk's body was covered in pustules that burst and oozed, and eventually incurable sores spread over the entire surface of Tissa's skin. His robes stank and stuck to him. Afraid of his state, the other monks in his monastery abandoned him. Having compassion on his isolated friend, the Buddha nurtured him back to health and instructed him before he died, enabling him to become spiritually awakened before death. The Buddha did not reprimand the monks who felt great shame, but reminded them that to tend to each other would be the same as caring for him. Through this story, Halifax defines the importance of the boundless abodes for caregiving and awakening. She remarks that awakening comes from compassion in action in the face of suffering that enables the caregiver to feel the world beyond her own storyline. The chapter argues that illness and death bring clarity to what patients and caregivers value as displayed through their actions. "From the moment of diagnosis, death becomes the bell that won't stop ringing," which awakens explicit awareness in patients and caregivers of what has ultimate value.[51]

Along with statements about the value of the boundless abodes in the face of the flesh's fragility, Halifax interlaces personal stories that exemplify their embodiment in ordinary acts of approaching death. She narrates her father's steadfast lovingkindness as he neared his last day, which allowed him to hold the balance between suffering and humor, showering grace on his caregivers and family alike. She tells a story of the Dalai Lama taking special interest in her wounded eyes, and saying a prayer of healing over her as he laid hands on the bandages. The story of the Dalai Lama permits Halifax to comment on the yoked-together and interactive nature of lovingkindness and compassion because they both spring from the fundamental realization that all beings are interconnected. For the Zen chaplain, the person who suffers is not separate from herself. Halifax shows how sympathetic joy takes delight in the good fortune and virtue of others, inspired to kindness in seeing kindness and inspiring kindness in the absence of hope. As the highest form of sympathetic joy, Halifax encourages an altruistic joy in caregivers that intentionally cultivates joyful responses to lift the spirits of the caregiver and their patients, explaining that neuroscience research indicates that joyfulness can be cultivated through practiced just like playing the violin. She ends the exposition of values with narratives about equanimity, showing

---

[50] Halifax, *Being with Dying*, Chapter 7.

[51] Ira Byock, "Introduction," in *Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death* (Boston: Shambala, 2008), Audible.

how letting go while being in touch with suffering cultivates the strong back that supports the caregiver's tender heart for those in pain. According to UZC, in service to these clinical goals, steady mindfulness practice permits chaplains to dwell in the boundless abodes.

In collaboration with Salzberg, Halifax and the other participants in the Professional Training Program for Compassionate End-of-Life Care at UZC formulated practices of blessing that she shares in her guided meditation. These practices strengthen the ability of caregivers to attune with others by making the boundless abodes live in the background of the mind and body so that they can come forward into explicit bodily experience in times of need. The presence of the abodes in their embodied presence permits UZC chaplains to transform suffering and death into freedom, using every obstacle on the path to find greater freedom and liberation. Bringing together modern and ancient narratives, Halifax connects these stories of the modern clinical scene with the figure of the Buddha, who is the source and quintessential expression of Buddhist values that clinical chaplains aim to embody in medical contexts.

The Neurobiology of Hidden Depths

A decade after *Being with Dying*, Halifax published a sustained dialogue between Zen values and a neuroscientific exploration of how the effects of mindfulness can be mapped through changes in brain structure. One of the most noticeable differences in *Standing at the Edge* is how thoroughly it integrates neurobiological frameworks into its narrative approach to teaching meditation practices and spiritual caregiving. This is partially the outcome of Halifax being in close dialogue with neuroscientists who study contemplation, through her publishing efforts and her creation of an annual UZC symposium that has brought together leading researchers and meditation teachers at the intersection of neurobiology and contemplative practice. The Zen Brain retreats held since 2001, later renamed the Varela Symposium in honor of Francisco Varela, have brought together leading humanist scholars and neuroscientists to dialogue about Buddhist forms of meditation practice. Researchers such as Richard Davidson, John Dunne, Al Kaszniak, James Austin, and Evan Thompson have presented their ideas at these symposia. To enhance clinical caregiving practices, Halifax intends to spread a working knowledge of neurobiology in the ranks of spiritual caregivers. To this effect, Halifax cites Tania Singer's research that suggests the "the act of tying in to our own visceral processes (heart rate, breathing, etc.) lights up the neural networks associated with empathy."[52] All this is to say, clinical chaplains can learn to monitor and modulate experiences of fear, sorrow, and aggression in themselves through meditation practices that sensitize them to their interior visceral processes. This body of research has become

[52] Joan Halifax, *Standing at the Edge: Finding Freedom Where and Courage Meet* (New York: Flitiron Books, 2018), 75.

essential scientific scaffolding for UZC's teaching of mindful spiritual care, as teachings given by Maull at the retreat that I attended in August 2018 made plain.

I see in Halifax's most recent book evidence of the turn to neuroscience in her own teaching and in the domain of spiritual psychology more generally. She is joined by several of her most important Zen colleagues. Amid the rapid spread of COVID-19, Fleet Maull unveiled what he is naming "Neuro-Somatic Mindfulness or NSM" in mid March, 2020.[53] At least in American Zen communities of practice, clinical care and neurobiological research are in a mutually informing dialogue. Halifax's literary career manifests the trends of this growing affinity. *The Fruitful Darkness* and *Being with Dying* map the first two stages of Halifax's career as a Zen teacher. Her work to integrate Zen and deep ecology and formulate the Zen of palliative care have prepared the way for her recent book that explores Zen values from a neurobiological standpoint in dialogue with narratives of personal experience. Teachings of the extended self cast self-other relationships as inherently mutual, reciprocal, and compassionate. At the same time, mindfulness meditation practices prove the key resource for chaplains in cultivating the embodiment of mind and the minding of the body so that compassion for self and other concurrently extends into attuned consciousness and appropriate action. When Zen chaplains integrate mindfulness and compassion into their clinical work, they change the nature of discussions around the responsibility of chaplains for giving care by expanding the categories of beings for whom they are responsible and defining a precise contemplative method for achieving spiritual presence. Halifax narrates stories from her own life and from the lives of others she has come to know firsthand or through her extensive reading on religious and spiritual matters. Understanding value constitution through narrative is a time-honored mode of studying the development of desired character traits, manifested in European and Asian virtue traditions alike, which maintain a continued presence in modern social life.[54] Halifax views the cultivation of values as the outcome of increased self-empowerment through contemplation and caregiving. The strength of a chaplain's body-mind connection is expressed and experienced as the power to live peacefully and skillfully in relationships, which is wedded to a character rooted in Zen values. The equanimity and compas-

---

[53] Fleet Maull, group email from Maull to the author and other subscribers, March 17, 2020.

[54] Alasdair MacIntyre, *After Virtue: A Study In Moral Theory* 3rd Ed. (South Bend: University of Notre Dame Press, 2018), Chapter 15, Audible. Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge: Harvard University Press,1989), 32-52, traces the continuity for seeing dialogical subjective interpretations of the self as whole; Cheryl Mattingly, *Moral Laboratories: Family Peril and the Struggle for a Good Life* (Berkeley: University of California Press, 2014) 20-21, integrates these philosophical views to her "narrative phenomenology of social practice." For a neurobiological view, Daniel Goleman and Richard Davidson, *Altered Traits: Science Reveals How Meditation Changes Your Mind, Brain, and Body* (New York: Penguin, 2018), 53-58.

sion that a Zen chaplain develops in the retreat setting directly responds to the requirement of biomedical institutions to provide collaborative compassionate care.

According to research being published by scholars of nursing, this Zen formulation of the embodiment of values meets a need that medical systems display. Medical systems require the development of principled action on the part of caregivers, and religious communities are predominant, though not exclusively so, in this work. For example, nursing researchers Kathryn Pfaff and Adelais Markaki formulate that "compassionate collaborative care" is a bundle of values like "empathy, sharing, respect, and partnership," which they base on their meta-analysis of compassion in end-of-life care.[55] They argue that this complement of values is clearly preferred by patients and families, who praise caregivers who come close enough to journey beside them as they suffer. They say that it is the ability to suffer alongside patients that proves so important to persons who receive care in hospitals. Pfaff and Markaki state, "the act of co-suffering, or suffering alongside a patient and family, is demonstrated through compassionate presencing, as well as recognizing and acting on the presence of patient-family suffering."[56] Zen is certainly not the only way by which chaplains learn how to suffer alongside patients and families, but it is an attractive option for doing this work because of its interdisciplinary approach that brings together religious and scientific expertise. Zen has a particular style that allows chaplains to suffer alongside patients by bearing witness. When a Zen Buddhist chaplain openheartedly bears witness to patient-family suffering, she prepares herself to respond with compassionate action that palliates suffering. Performing these actions in the medical domain translates Zen into biomedical culture while actively reinventing the tradition of American Zen in a medicalizing mode. In practicing Zen contemplative care, Zen chaplains contribute to the ongoing reinterpretation of American Zen and translate Zen into a biomedical context.

In her work of translating Buddhist values into healthcare, Halifax interweaves neuroscience discourse into her evolving discussion of Zen spiritual care. Compassion has a long history in Buddhist writings, but current contemplative neuroscience research shows with greater clarity in studying groups of subjects trained in contemplative methods how it differs from its close cousin empathy. Halifax refers to research published by Tania Singer, Olga Klimecki, and their colleagues, which explains how compassion training and empathy training activated differentiated

---

[55] Kathryn Pfaff and Adelais Markaki, 2017. "Compassionate Collaborative Care: An Integrative Review of Quality Indicators In End-of-Life Care." *BMC Palliative Care* 16 (2017), 15. See also Christina Puchalski,"The Role of Spirituality in Healthcare," *Baylor University Medical Center Proceedings* 14 no. 4 (October 2001): 355.

[56] Pfaff and Markaki, "Compassionate Collaborative Care," 15.

neural networks in trained groups.[57] Contemplative methods cultivate top-down and bottom-up control over which neural circuits and corresponding forms of consciousness are active in caregiving, which can be used adaptively to reduce empathic distress. Since empathy training increases activity in neural networks that correspond to negative valence while compassion training increases activity in neural networks that correspond to positive valence, compassion training can be empower caregivers to counteract feeling overwhelmed by negative emotions that linger after empathizing with patient pain, fear, anger, sorrow, or loss. Along with demonstrable changes in the activation of neural networks, compassion practices lead to a corresponding change in the quality of emotional experience. Those who cultivate compassion systematically describe it with words related to warmth, happiness, and expansion. As a poignant version of this subjective quality of warmth, Halifax narrates Tibetan Buddhist monk Matthieu Ricard's accounts of his interior experience. "Matthieu described his experience during the compassion mediation as a warm positive state," she writes, "coupled with a strong desire to be of service" to the distressed children he saw represented in images.[58] This research argues that in Zen Buddhist communities of practice, compassionate responses enliven, connect, and energize relationships. Halifax continues, "This was in distinct contrast to his earlier experience with empathy (actually empathic distress), which was completely draining and debilitating."[59] Empathic response could be likened to sharing a wet blanket, while compassionate response is more like sharing a warm seat by the fire. I am not making an argument against the present of intense feelings of distress or using empathy in clinical work, but I am arguing that caregivers can work more skillfully with empathy by transforming it into compassionate action.

Highlighting this distinction, the authors of the Klimecki study say that "the generation of compassion focuses on strengthening positive affect, while not ignoring the presence of suffering or changing the negative reality."[60] Besides the activation of other neural circuits, empathy training activates the entire insular cortex, making the pain of others and oneself more resonant in experience. "In contrast to empathy training, cultivating feelings of kindness, warmth and con-

---

[57] Halifax, *Standing at the Edge*, 71-75. For alternate Zen teachings integrating neuroscience, see Fleet Maull, *Radical Responsibility: How to Move Beyond Blame, Fearlessly Live Your Highest Purpose, and Become an Unstoppable Force for Good* (Boulder: Sounds True, 2019), 40; For the neuroscience perspective, see Olga M. Klimecki et al. 2014. "Differential pattern of functional brain plasticity after compassion and empathy training," *Social Cognitive and Affective Neuroscience* 9 no. 6 (2014), 873–879, https://doi.org/10.1093/scan/nst060; see Tania Singer and Olga M. Klimecki, "Empathy and Compassion," *Current Biology* 24 no. 18 (2014), R875-R878; Tania Singer and Boris Bornemann, "A Cognitive Neuroscience Model: The ReSource Model," in *Compassion: Bridging Practice and Science* eds. Tania Singer and Matthias Bolz (Leipzig: Max Planck, 2013).

[58] Halifax, *Standing at the Edge*, 72.

[59] Ibid.

[60] Klimecki et al., "Differential Pattern Brain Plasticity," 877.

cern induced non-overlapping brain changes."[61] The compassion circuit draws together neocortex, midbrain, and brain stem, resembling the pattern associated with finding material rewards, maternal love, and romantic love, all of which carry a positive valence. In contrast, empathy training activated neural circuits associated with processing negative valence. Meta-analyses of compassionate caregiving find similarly that "compassion extends empathy beyond merely understanding and acknowledging another's experience, to include actions that are motivated by love and acts of kindness."[62] This is an important body of research to master for a Zen teacher of mindfulness and compassion because it demonstrates in neurobiological terms the adaptiveness of compassion. Such neuroanatomical warrants have enormous currency in biomedical contexts, providing a legitimacy for spiritual care in medical institutions. According to neuroscience findings, compassion acts to render caregivers more resilient in the face of pain and distress. It does so by functioning as an affective reward that strengthens interpersonal affiliation and prosocial action. When Zen chaplains master practices that enable them to take compassionate action, they prepare themselves to confront harsh realities with less empathic distress. In *Standing at the Edge*, Halifax marshals neuroscience knowledge to make claims supported by strong empirical evidence about the adaptiveness of compassion. She can then speak persuasively to caregivers working in biomedical settings, deploying this same knowledge as part of a Zen Buddhist discourse. Medicalizing compassion training means speaking an idiom that defends Zen practice in neurobiological terms.

Meditation teachers like Maull and Halifax are not content with gaining conceptual knowledge. They want to know the feel of values through embodied experience, though successes and failures in the practice of care. Failure instructs a Zen chaplain as eloquently as death. Halifax maintains that falling down in the attempt to embody values like the boundless abodes set forth in Zen vows goes with the territory of American Zen practice. For this reason, *Standing at the Edge* reads like a collection of the aphorisms of an experienced guide callused by falls and failures who stands at the border between the skillful step to stay on the path and the blundering footfall that slips into distress. She names six values—the *paramitas* of generosity, virtue, patience, wholeheartedness, concentration, and wisdom—that orient attuned human interaction. These values fall into the categories of three embodied powers: motivations (energy), feelings (affects), and personalized rational aims (teloi). The values have a power that extends beyond personal experience, yet they can only be known through a caregiver's embodied sociomoral world, and they manifest themselves in particular events, actions, and interior qualities of emo-

---

[61] Ibid., 878. See Appendix A for a discussion that goes into more detail about the links between empathy, compassion, and contemplative practices.

[62] Pfaff and Markaki, "Compassionate Collaborative Care," 19.

tion and thought. Each value has prosocial implications, animating chaplain actions intended to benefit various levels of society in a way that religious and psychological discourse can rationally elaborate. However, each value has a shadow side. When applied unskillfully, each can cause harm, especially when the chaplain applies it without properly attuning to the clinical situation she encounters. For example, an altruistic action can mean "forgetting the self,"[63] but it can also be "help that harms."[64] Halifax remembers an event from her own life when she tried to save a beached porpoise only to cause it more pain. Like in this story, pathological altruists keep suffering beings bound in need instead of setting them free through liberating action.

The antidote to pathological altruism is sharing wisdom to see how and why pathological altruists do not empower all beings to take motivated action to help themselves to the degree they are able. It involves a wisely compassionate friend holding up the mirror of insight in such a way that a pathological altruist might be able to see her own maladaptive patterns without defensively protecting herself. The six perfections provide the basis for finding perspective that enables one to skillfully apply values, which include the wisdom produced by mindfulness. As Halifax writes: "the six paramitas, or perfections, of Buddhism are the compassionate qualities that bodhisattvas like Avalokiteśvara embody: generosity, virtue, patience, wholeheartedness, concentration, and wisdom, giving us strength and balance as we stand on the edge."[65] Generosity means a chaplain freely gives her resources even when a she knows they are in short supply. Virtue means living by vow even when the chaplain fails to fully embody the precepts she has taken. Patience means a clinical chaplain lets go of aggression and reactivity even when she feels powerless to control outcomes. Wholeheartedness means chaplains participate in a community of practice doggedly and cheerfully despite setbacks and discouragement. Concentration means a chaplain cultivates attentiveness even when she wants to avoid painful situations. Wisdom means the chaplain does whatever necessary to maintain the ability to perceive reality clearly even when she has self-interested reasons for seeing only one side.[66]

The *paramitas* are the bastion of strength in values passed on between generations of Zen Buddhists, contextualizing and anchoring altruism. They keep clinical chaplains from falling over the edge into pathological forms of helping, providing a basis of support for the master value of clinical chaplaincy, compassion (which I will discuss in the section below). These values must be reinvented by Zen chaplains in the context of their own lives, personal qualities, and local healthcare institutions. When a Zen Buddhist clinical chaplain embodies the perfections in all

---

[63] Halifax, *Standing at the Edge*, 19-20.

[64] Ibid. 22-25.

[65] Ibid., 223.

[66] See Halifax, *Standing at the Edge*, 223-228, for description of the six *paramitas*.

circumstances, it signals that she has crossed over from the world of human suffering that characterizes samsara to the other shore of nirvana. She has realized a non-dualist enactment of the *dharma*. In her wisdom, she has become perfected in the sense that she no longer reacts to pain and suffering as if they were separate from bliss even while she remains firmly connected to suffering in herself and others. She remains rooted in equanimity even in encounters rife with fear, anger, sorrow and despair. In her meditation practice, the six *paramitas* define a pathway by which she has recovered, maintained, and enhanced this balance. Halifax's teaching reasons that the embodiment of these perfections in the Zen chaplain endows her with the resiliency and skillfulness to meet the needs of her clinical institution. Besides this, it endows her with the clarity of insight to notice and propose changes to clinical regimes that may better serve the needs of patients, families, and the clinical teams who care for them.

Compassion as Strong Evaluation

Just like any other chaplain—Catholic, Secular Humanist, Jew, Muslim, Protestant, etc.—would bring her value structure via her embodied presence onto the clinical scene, the Zen Buddhist chaplain, as one who practices mindfulness and compassion, brings the fruits of her practice into her spiritual caregiving work. Her practice of spiritual caregiving is also a practice of loving the particular patients she encounters, humanity, and the world more broadly. If the mindful chaplain gains a greater capacity to embody the *paramitas*, whether because she finds her ultimate ground in equanimity or lovingkindness, she realizes what Halifax calls her extended self. When she provides care in a skillful and compassionate way, she incorporates these six perfections into herself and expands her mind and field of embodied perception to encompass more of her experience in its totality with less fragmenting of herself by the exclusion of elements she does not like. In this work, compassion plays the role of a master value—"a strong evaluation"—that structures all the other value expressions in her economy of the good.[67] This does not mean that all Zen chaplains will understand or embody compassion in the same way, and any chaplain would be able to justify her position in dialogue if she held another value like (wisdom or altruism) in higher regard. Yet most American Zen chaplains feel the ultimate desirability of compassion and believe that the truth of compassion is written into the structure of reality. For them, acting compassionately becomes an ontological demand that issues from the wisdom of perceiving the non-separation of selves. These Zen chaplains hold that compassion frames all other standards of action, motivation, and emotion; compassion stands "independent of these and other

[67] Taylor, *Sources of the Self*, 4, 14, 20, 42, 122, 332, 333, 337, 383.

standards by which they can be judged."[68] This is because the embodied wisdom of Zen chaplains restructures their perception of subject-object relations in such a way that they incorporate more fully the experience of the world's others into their own sensation, emotion, thought, and motivation. Zen wisdom provides chaplains with the means to relax the boundedness of selves without dissolving the uniqueness each self feels as a nodal point of consciousness in the web of interconnected beings. Along these lines, Halifax proposes a means by which to develop this kind of discernment in *Being with Dying*, guiding a visualization of the interior world of a person who suffers.[69] This guided visualization is based in more traditional forms of lovingkindness meditation in Mahayana traditions.

Studying at UZC brings into focus one essential element of strong evaluations in relationship to caregiving: how they arise in a complex dialogue involving the caregiver and the communities of care and meditative practice in which she participates. The clinical chaplain refines her views about her responsibilities as a caregiver in the context of a religious community in which she cultivates a sense of her values through spiritual practice. Initiated in an American Zen community, the compassion she feels, enacts, and orients herself toward, extends into a clinical setting at a hospital or hospice. At the same time that she cultivates a mature sense of compassion, she engages in a community of spiritual caregiving. *Dharma* and *sangha* delimit the practice and context of value genesis in American Zen clinical chaplaincy, yet the caregiver must ratify the values she cultivates in the retreat setting by translating them into the clinical context. For contemplative chaplains trained at UZC, the knowledge they have of compassion arises from the internal interaction of the chaplain's body, extended nervous system, and mind in the context of external interactions with other bodies, extended nervous systems, and minds in both retreat settings and clinical domains. This integration of body, extended nervous system, and mind—first on retreat and then in the clinic—leads to greater discernment and greater potentials for harmonization across bodily and social systems.

In a clinical setting, discernment between help that serves and help that harms requires the experience and wisdom generated through interpersonal relationships in a community of practice—practicing mindfulness or compassionate care respectively. Personal narratives about lived events that transmit the knowing of a tradition are the best way to describe how chaplains cross the borders between realms of clinic and zendo because they show the wisdom of seeing both realms as integrated through personal experience. Halifax writes about the importance of this

---

[68] Ibid., 20.

[69] Halifax, *Being with* Dying, Chapter 3.

kind of wisdom, and its inextricable link to compassion in American Zen, and she does so in a way that foregrounds her personal experience.[70] She says:

> From a Buddhist perspective, caring, love, kindness, compassion, and altruistic joy are highly valued qualities. And yet, sometimes help harms. And here, wisdom is essential. Buddhists do not separate wisdom from compassion. These qualities are two sides of the same coin of our basic humanity.[71]

Looking at the Janus face of the practice of embodying *paramitas* as values, Halifax distinguishes between these six values and their shadow sides: 1) healthy altruism/pathological altruism 2) empathy/empathic distress, 3) integrity/moral suffering, 4) respect/disrespect, 5) engagement/burnout, and 6) compassion/its enemies. Her narrative fuses American Zen perspectives on such traditional knowledge as the six perfections[72] with novel perspectives on elements of chaplaincy practice that align with Buddhist values such as "deep listening."[73] Just as the six perfections ground compassion and bring it into the flesh of lived experience, compassion guides the value structure that Halifax articulates.

The late modern Zen clinical chaplain undertakes a kind of balancing act, poised between critical distance and intimate connection. American Zen chaplaincy invites feeling the marrow of an experience and then letting this experience go to achieve freedom from all experiences in the boundlessness of the mind. According to Halifax's teachings on the *paramitas*, Zen chaplains strive to avoid unresponsiveness just as much as they strive to avoid intrusive helpfulness. Halifax's narratives about her own clinical practice and the clinical practice of caregivers in the field show the complexity of this balancing act. The late modern hospital, Halifax says, is a charnel ground where caregivers confront forms of suffering that destabilize the conventional self. American Zen teachers in the White Plum Lineage who follow in the legacy of Bernie Glassman have reclaimed these charnel grounds as sacred space. They focus on limit experiences, and death in particular, and this is not merely a late modern reinvention of American Zen Buddhism. Various schools of Buddhism have maintained similar practices since Buddhism's institutionalization into a monastic system in South Asia. This practice is more so contrary to habits of moderns: to intentionally visit charnel grounds to serve those who suffer runs contrary to the practices of most late modern people who avoid the hospital unless they or family members are sick and confined to a

---

[70] I will analyze how Halifax personalizes the *dharma* of compassion through reflection on her own lived experience in the next section.

[71] Halifax, *Standing on the Edge*, 25.

[72] Ibid, 223-229.

[73] Ibid, 82-83.

bed in it. Modern culture, according to Halifax, goes to great lengths to deny the reality and finality of death, attempting to disjoin inextricably entwined elements of human experience. To enter a hospital and bear witness to the seamless routines of curative medicine exposes this truth: modern and late modern hospitals are no place for dying.[74] The siloing of dying persons shows the logic of modern institutions that reinforce the death denial of the mainstream by making death nearly invisible in everyday life. As an antidote, Halifax recommends that late modern persons "retrieve visions of dying" that take as fundamentally true that life and death are inextricably intertwined.[75] Halifax shows how spiritual practices in community orient thought, sensation, perception, motivation, and action toward a dignified death. Sources of moral experience lived out in practices that cultivate the "caring, love, kindness, compassion and altruistic joy" she names come to life in communities of practice, whose members shape themselves in dialogue with the literature of vital religious traditions and the moral practices of giving care.

Halifax as an Exemplar of Boundless Compassion

As the founder and leader of UZC and an innovator in Zen palliative care and Zen clinical chaplaincy Halifax embodies new somatic modes of attention that bring into awareness caregiver experiences of feeling empathy for suffering patients in an explicit way. In the way that she imagines and experiences compassionate response, compassionate care transforms a caregiver's empathy into action on behalf of the other. Halifax's version of compassionate care is nurtured in the religious community of UZC, a community of care embedded in the Zen lineage of Maezumi that reinvents the traditions of Zen Buddhism as inflected by the cultural legacy of the Meiji period, the American counterculture, and the neurobiological turn. The New Buddhism of Japan at the turn of the twentieth century has become the socially engaged Buddhism of the United States after the 1970s.[76] Socially engaged Buddhism as practiced at UZC has crystallized into a value system scaffolded in neurobiological terms that orients UZC's spiritual caregiving and palliative care. As an innovator in the medicalization of Zen traditions, Halifax bases her views in Zen teachings. In line with these cultural roots and the value ultimacy of compassion, she ends her exposition of American Zen values by referencing the teachings of fourteenth century Rinzai Zen Master Muso Soseki on the three forms of compassion: 1) "referential compassion,"[77] 2) "in-

---

[74] See Helen Stanton Chapple, *No Place for Dying: Hospitals and the Ideology of Rescue* (Walnut Creek: Left Coast Press, 2010), 7-23, especially the section titled "Universal Rescue Destabilizes Death" (12-13).

[75] Halifax, *Being with Dying*, Chapter 6.

[76] Lopez, *Buddhism and Science*, 20.

[77] Halifax, *Standing at the Edge*, 215-216.

sight-based compassion,"[78] and 3) "non-referential compassion."[79] As the strong-evaluation of American Zen, non-referential compassion is the endpoint of the teleological vision of American Zen. It is clear from how Soseki orders this framework and the stories that follow that non-referential compassion is an ultimate form—the strongest form of strong evaluation in Soseki's estimation. By ending her book with this teaching, Halifax is saying that this ultimacy of non-referential compassion also holds true for UZC and late modern American Zen. That is to say, the most powerful examples of compassion's healing energy emerge in moments when compassion elicits the desire in all subjectivities for the healing of all afflicted bodies without reference to specific bodies in specific times, places, or social constellations.

In the case of non-referential compassion, compassion has no object per se and is at the same time experienced by subjects universally. Following earlier exemplars of Zen, Halifax is universalizing "non-referential compassion" as the ultimate value of awakened human consciousness in sentient, sacred space. This is a teleological argument that applies to her own lived experience as a personal quest for self-awakening that has implications for her status as an exemplar in her community, which exercises normative force in shaping the experience of her students. As Margaret Urban Walker says of the normative force of "dominant identities," "some lives stand out for notice as obvious or best cases of persons, while others fail to stand out clearly, or in their own terms, or at all."[80] Thus, Halifax, by constructing an embodied hierarchy of compassionate action that begins with situated acts of compassion that attempt to free unique beings from suffering and ends with compassion as a mode of acting without considering attention to particularities as necessary, is constituting her life as one that stands out for notice in a certain way. She narrates her life as if her life were exemplary. In her embodiment of Zen, but not unique to her embodiment, non-referential compassion universalizes compassion as an ultimate value, so that a chaplain who embodies it like Halifax does will resourcefully find compassion in her body regardless of her circumstances. In fact, compassion will work through her as the flesh in which it embodies itself, because the non-referentially compassionate chaplain will no longer ground herself in a concept of self that claims credit for enacting compassion. In Halifax's interpretation, if a chaplain embodies non-referential compassion, her sense of selfhood will no longer be confined to her physical body or mind. As an extended self, she will identify with all sentient beings.

Beginning with an understanding of the particularity of social locations makes sense in terms of referential compassion. Referential compassion takes particular human beings as an object. When a clinical chaplain practices it, she actively wishes for the wellbeing of social others. Ac-

---

[78] Ibid., 216-217.

[79] Ibid., 217-220.

[80] Walker, *Moral Understandings*, 149.

cording to Zen, referential compassion is in no way deficient. It is merely the ordinary preliminary to insight-based and non-referential compassion. Insight-based compassion carries with it the sense that compassion is normative, encompassing "the understanding that compassion is a moral imperative."[81] In other words, "responding to suffering with compassion is the 'right' thing to do" or the high moral ground.[82] Non-referential compassion goes beyond morality because it is boundless. Boundless, non-referential compassion is the accompaniment of a highly developed sense of open awareness, the boundless abode that dissolves subject and object relations within and across bodies into one seamless, non-dual organism. It emerges spontaneously, selflessly, and without any particular responsible party in moments when the personhood of the compassionate chaplain functions as a conduit through which the sentiments of suffering with others while wishing them to be free of suffering express themselves.

This view on compassion holds that compassion in its most refined form, open and unfettered by self-referential processes that serve to protect the human organism, arises on its own. Though an object initiates the influx of non-referential compassion into a bodily vessel, it overflows the boundaries between selves and fills the space between subjects. In this sense, non-referential compassion epitomizes intersubjective processes in the way that Fleet Maull or Daisuke Saito and colleagues use the term.[83] "To have non-referential compassion," Halifax writes, "is to have a heart and mind that are open to the suffering of all beings and ready to serve in an instant."[84] In the Zen perspective, illusions of separateness fall away and the boundless extended self opens to giving. "As the illusion of the small self falls away," Halifax says, "we remember who we really are."[85] Her words remember that the Sanskrit word *smrti* (Pali: *sati*), that is mindfulness in meditation practices, indexes the meditator's recollection of her own basic nature that flow into the consciousness of a particular caregiver at a particular moment in time, whether in formal or informal moments of practice.[86] Non-referential compassion is mindful awareness that grounds a

---

[81] Ibid., 217.

[82] Ibid.

[83] Maull, *Radical Responsibility*, 217; Michael Spezio, "Social Neuroscience and Theistic Evolution: Intersubjectivity, Love, and the Social Sphere," *Zygon* 48 no. 2 (June 2013): 428-438; Daisuke Saito et al., "'Stay Tuned': Inter-Individual Neural Synchronization During Mutual Gaze and Join Attention," *Frontiers in Integrative Neuroscience* 4 (November 2010): 1-12.

[84] Halifax, *Standing at the Edge*, 221.

[85] Ibid.

[86] Rupert Gethin, "On Some Definitions of Mindfulness," *Contemporary Buddhism* 12 no. 1 (2011): 270. See his argument about the translation of *sati* from the Pali texts carrying with it features of memory or right remembrance. Gethin says, "I do not want to suggest by this that mindfulness is conceived in terms of a series of conscious and discursive reflections along these lines, but simply that ancient Buddhist texts understand the presence of mindfulness as in effect reminding us of who we are and what our values are."

caregiver in the boundless abodes of the extended self in service to all others. This tendency to extend compassionate care beyond patients to families and caregivers is not unique to Zen chaplaincy, yet Zen chaplaincy has a potent rationale behind the expanding the category of beings for whom chaplains are responsible to care.[87]

To drive home the importance of non-referential compassion, Halifax shares a personal narrative that relates how non-referential compassion has expressed itself in her life. Importantly, the story takes place in the clinical setting, which means that Halifax's experience of non-referential compassion lends itself to medicalization. She begins by telling of a serious injury she suffered to her leg getting out of the shower during a trip to Toronto. In fact, Halifax broke her leg in three places, and her injury left her in great pain. As an EMT rides with her in the ambulance to the hospital, with a mind focused by the energy of her own intense pain, Halifax looks at his tired face with compassion, noticing that he was weighed down with heavy news. She writes: "Without thinking, I touched his knee and asked if he was all right. It was a strange question for me to be asking under the circumstances but it arose out of nowhere, the kind of nowhere that is there during deep meditation, the nowhere that is present when pain has eclipsed the self."[88] The EMT confides in Halifax that his wife is dying of cancer. This tale makes visible the truth that one can feel isolated and imprisoned by great pain, but one can also feel liberated by it. Ostensibly, the difference in how a caregiver responds to pain derives from how she uses her awareness to engage with the elements of her bodily experience and external phenomena. Pain can clarify reality if the caregiver has practice in coming closer to it without fear. In Halifax's story, compassion comes "without thinking"—out of nowhere (nothingness)—and works to yoke together two sufferers in warmth and nurture. Halifax never learns the EMT's name, but he sits next to her side for many hours, like a surrogate husband vicariously tending to his suffering wife. This shows how a caregiver's empathic bond, developed in the context of sharing vulnerability, leads to compassionate action and interpersonal healing, when past trauma and grief primes the two constellating, conventional selves to act out the higher impulses of the extended self that American Zen imagines is not bound by the physical limits of the body.

This is not to say that Halifax is holding herself up as perfect in her embodiment of these values. In the chapter entitled "Respect," she relates a story in which she used humor to deflect her fear while teaching a hardscrabble prison inmate named John, which had harmful consequences. When John explosively rejects her use of *metta* in a prison meditation group, Halifax looks at him and says "I agree with what you are saying. I just don't like how you are saying

---

[87] In essence, Zen chaplaincy necessarily extends to the animal, plant, and mineral worlds and their forms of sentience, which is the logical entailment for spiritual caregiving based on Halifax's definition of the extended self in relation to different forms of sentience in the world system.

[88] Halifax, *Standing at the Edge*, 219.

it."[89] The room melted in laughter, but John was forcibly removed from the room, and Halifax was grateful for the detente. She saw John one year later (in the meantime he had killed another inmate) being strip-searched in the hallway. John looked at her with an aimless rage as he was being humiliated by the guards, and Halifax reflected on her earlier "defensive and humorous remark."[90] Her defensive actions potentially turned John away from the *dharma*, and she deeply rued the harm they had caused. She writes: "John was being stripped of his dignity along with everything else. As much of a bully as he was, the correctional officers holding him were even more powerful as oppressors, asserting their disrespect and dominance with a sense of utter indifference, as though they were handling an inanimate object."[91] The display of "vertical violence and systematic oppression"[92] made her nauseated as she walked down the hall.

To put into relief how far she falls short in living up to her ethical ideal, she recounts the story of the Buddha's meeting with the serial killer Angulimala.[93] Whereas the Buddha turned Angulimala to the *dharma*, Halifax brought John no closer to freedom from the endless violence of his life. Halifax laments: "In thinking about the story of Angulimala, I realized that I had missed my chance with John. John had murdered three men. He was tough, but in looking more deeply, I could feel he was broken. There was no way to go back in time, and I was never to see him again. But he has stayed with me, as a lesson in failure."[94] The emotional tone of this story reflects Halifax's regret and sorrow, and I see in it her self-accountability as a bearer of a dominant identity for her role in reinforcing the oppression faced by a marginalized person. The inclusion of this tale shows Halifax's awareness of her moments of moral failure. John bore an identity that most persons would hold in contempt, and Halifax did very little to differentiate herself from the vertical violence to which she bears witness. This experience is perhaps one of the most valuable in the book, for teacher and students alike, because it dispels the notion that mindfulness or *metta* have magical powers that heal all wounds. For reasons that human beings can rarely explain, helpful teachings fall on deaf ears. In either case, success or failure, to embody the highest values of American Zen promotes the kind of interpersonal, contextual learning that makes use of each experience as a constituent element on the path to spiritual awakening.

Halifax embodies the *dharma*, imperfectly but powerfully, that she received from numerous Zen Buddhist teachers of different modalities—Seung Sahn, Thich Nhat Hanh and Bernie

---

[89] Ibid., 154.

[90] Ibid.

[91] Ibid., 155.

[92] Ibid.

[93] Ibid., 155-157.

[94] Ibid., 157.

Glassman—in the context of the American Zen *sangha* since the 1960s. Yet, she expresses these teachings in a novel synthesis that reinvents Zen approaches to spiritual caregiving in medical settings. Prior to her attraction to Zen Buddhism, she came of age in a religious milieu in which liberal Protestant reading practices had disseminated intellectual knowledge about spiritual psychologies and other religious traditions in politically and religiously progressive Protestant communities in the first half of the twentieth century. Responding to the needs for spiritual growth in herself and her generation of social activists, Halifax also took advantage of the presence of Zen Buddhist teachers in the US after the change of immigration policy in 1965. As an anthropologist schooled in the methods of participant observation and ethnography, she learned how to participate in and observe the Zen art of awakening to the truth of the extended self. She learned how to integrate the teachings of Zen with social science discourses, which enabled her to serve as one of the foremost innovators in American Zen, deep ecology, and Zen spiritual and palliative care in a neurobiological key. Along with most other Zen teachers of her generation like Fleet Maull, Halifax is white, middle-class, grew up in a Christian household, has a history of formal education, was involved in the 1960s counterculture, and is indebted to Bernie Glassman's vision of an order of Zen Peacemakers that encompasses religious practitioners from numerous traditions. As a complement to the diversity that ZPO intends to include, it holds a strong commitment to spiritual universals that the American Zen chaplain embodies in her somatic awareness and in her caregiving practices.

Entering the charnel grounds of the hospital armed with neuroscience explanations of meditation, Halifax spiritualizes medical care from the standpoint of American Zen values. At the same time, she medicalizes mindfulness by adapting the mindfulness and *zazen* teachings and practices of the various teachers who transmitted Zen *dharma* to her. She translates Maezumi's and Glassman's *dharma* of wisdom-compassion into a medicalized idiom so that caregivers can discover the extended self in service to suffering patients and families in biomedical contexts. In translating meditation practices into an idiom acceptable to medical caregivers, she medicalizes American Zen in dialogue with neuroscience explorations of the effect of contemplation in the cultivation of values. Responding to the needs of medical institutions for models of compassionate care, Halifax actively reinterprets the *dharma* of wisdom-compassion to reshape it to fit with the work of giving spiritual care in late modern medical institutions. This translation work has affinities with humanistic psychology, which reclaimed the integrative and wholistic approach of spirituality, yet goes beyond them in its mapping of interiority. American Zen defines the growing maturity of spiritual caregivers in terms of a widening concern for others that leads to compassionate action on their behalf. These American Zen spiritual caregivers will come to see "the

true nature of life and death,"[95] and respond to others with receptive and compassionate caregiving. It is not surprising that Halifax's core philosophical content and practical instructions bear a strong resemblance to the teachings of Maezumi since he transmitted core Zen traditions to her primary teacher Glassman. What is creative and novel about Halifax's teaching is how she reinvents American Zen to appeal to the specialized medical audience who receives it at UZC by integrating neurobiological interpretations of Buddhist values. In the hands of Halifax, American Zen is ecologized, medicalized, and neurobiologized.

The content of Halifax's message is not the object of my critique, but I do feel a desire and moral responsibility to offer a critique of the social effects of Halifax's message and the way that she has relentlessly marketed it. Halifax has created herself as an American Zen hero through a process of self-mythologizing, and this has the social effect of accruing social esteem and power to her and her community. She gives a self-aware nod to this effect and her involvement in constituting it with her references to the shadow side of altruism or her subtle disrespect of John. This process of mythologizing the roshi creates imbalances in the distribution of power in the field of clinical chaplaincy education, because Halifax practices forms of self-cultivation privileged with neurobiological warrants and represents her practice in such a way as to highlight these warrants. Halifax's self-aware fashioning of a dominant identity has an ironic quality to it. Though Zen emphasizes the teachings of no-self and impermanence, many Zen teachers like Halifax and Maull relentlessly market themselves and create a dominant identity founded on personal charisma and acumen in neuroscience. In terms of my own personal-emotional relationship to this dynamic, it gives me pause, induces me to practice humility, and restrain my self-expression in interfaith engagements, so as to pay close attention to the identities that do not display so obviously the synergy of contemplative religiosity and disciplines of science.

---

[95] Erik Erikson, *Insight And Responsibility: Lectures On The Ethical Implications Of Psychoanalytic Insight* (New York: W. W. Norton and Co., 1964), 131.

Chapter Four

Spiritual Maturity in Mindful Spiritual Care

> No one escapes this inevitable law. Death is a logical consequence of birth and begins to work on life at the moment of birth. There are no exceptions. Differences in wealth, education, physical strength, fame, moral integrity, even spiritual maturity, are irrelevant. If you don't want to die, don't be born.
>
> —Larry Rosenberg, "The Third Messenger"

In the previous chapter, I described how Halifax ecologized, medicalized, and neurobiologized American Zen. In her work of translating Zen into medical contexts, she built on the religious reading practices, seeker spirituality, and the influence of Romanticism that transformed religious practices in twentieth-century America, paving the way for the rise of American Zen and the space for its premises and practices to come into dialogue with other religious traditions, state institutions, and academic disciplines, including psychology and neuroscience. In this chapter, I examine two matching faces of this change: the spiritualization of psychology and the medicalization of spirituality. As liberal Protestant writers and pastoral caregivers integrated spirituality into psychology (and vice versa), they prepared spiritual care for increased integration into secular biomedical contexts (and, again, vice versa). In effect, best practices for "patient-centered care" in medicine have come to recognize spiritual dimensions of human experience, which are not associated with any particular religious institution, but are seen rather as the property of a universal human experience which has been construed as the mysterious inward relationships of human being, another legacy of Romanticism. Inspired by spiritual psychologies, medicalized American Zen's approach to these spiritual dimensions has manifested as a healthy appreciation for the uniqueness and ineffability of the 'real self'—Halifax's extended self—a space of creativity in relationship with human and nonhuman entities.

To make Zen more transparent to American audiences, key cultural translators of *buddha dharma* like Joan Halifax and Fleet Maull use idioms to relate their teachings through these already established spiritual psychological frames. They have turned the *dharma* toward the problems of social justice that interested well-educated white liberals who came of age in the Civil Rights era. While applying the *dharma* to social problems, they found resonances between Zen and ecology and between Zen and spiritual caregiving, as I detailed at length in Chapter 3. They incorporated Zen teachings about empathy, kindness, and compassion into reform movements that aimed to improve biomedical care by making it more holistic. In league with a growing

army of neurobiological researchers, they medicalized mindfulness practice, scaffolding ancient contemplative practices in rationalizing language that enabled the further medicalization of spirituality. They mapped changes in interior anatomical structures that correlated with the subjective experiences of authentic spiritual transformation. Clinical chaplains played an essential role in this work, as the people who enacted and adapted the views and practices of their spiritual preceptors and teachers by importing them into various dispersed local institutions of medical care. In this chapter, I share the experiences of some of these chaplains, gleaned through my own experience and through interviews with several other chaplains, to examine how UZC's practices are learned, integrated, embodied, and circulated. I explore how chaplains come to the calling, often through a transmutation of their own suffering in group relationships. And I look specifically at how chaplains trained at UZC constitute mindful spiritual care and thereby medicalize mindfulness.

My interest in this chapter is thickly describing how American Zen chaplains constitute certain types of personal experience in dialogue with Zen instruction about methods of contemplation, the nature of the self, and spiritual caregiving. I bring together three streams of discourse: the stories of my informants, my personal experience as a spiritual caregiver, and instruction provided by UZC. I coordinate these streams of discourse with neurobiological discourse that describes the inner processes of change that unfurl in the embodied minds of Zen chaplains as they practice mindfulness and caregiving. As the processes of interior change of Zen chaplains taught at UZC occur in reciprocal relationship with discursive processes that reflect the spiritual maturation of students, arguments that suggest that Zen inscribes or invents the self it describes in the consciousness of Zen chaplains cannot be dismissed. There is a certain amount of truth to this perspective articulated by critical voices like Nikolas Rose quite forcefully in his analysis of how psychology invents versions of the late modern self.[1] Yet American Zen teachers like Halifax would say that they merely use natural means of concentrating the mind so that the reality of the extended self can emerge. For them, the processes of self-constitution can best be described

[1] Rose, Nikolas Rose, *Inventing Our Selves: Psychology, Power, and Personhood* (Cambridge: Cambridge University Press, 1998), 77-79. Rose is theorizing in a close dialogue with Michel Foucault. See for instance where he explains the genealogy of psychology as a method of constituting the citizen subject in the subsection "The Soul of the Citizen" (77-79), through which he shows how "multiple humanistic and concerned professionals" (79) instruct modern subject-citizens in the arts of "living our lives according to a norm of autonomy" (79).

as a discovery or retrieval, which betrays American Zen's affinity with Romanticism.[2] I do not seek to deny the critical truth claims of Rose's position, neither do I entirely endorse it. It is a way of looking at the constitution of the self that reveals some of the blindnesses and biases created when teachers embody the dominant identities of American Zen in a way that accrues them power and obscures the marginalization of disfavored identities and their particular social locations and bodies. As the narrative shape of this chapter indicates, in my own process of self-constitution and spiritual caregiving, I find greater resonance with philosophers and teachers who affiliate more closely with the Romantic position, but the critique of power also has its place.

The Mindful Spaces of Inner Chaplaincy

It is to various accounts of spiritual maturation and compassionate care cultivated at UZC that I now turn, as a means of articulating Zen Buddhist practices of mindful spiritual care and the logics they embody. To understand the importance of the material and interpersonal context responsible for the development of the values of chaplains UZC trains, I visited UZC during a retreat entitled "Attending to Pain and Suffering with Compassion, Wisdom, Clarity, and Resilience" led by Maull. As former students of Bernie Glassman, Maull and Halifax have a close connection that is also built on their shared historical context as white counterculture spiritual seekers who were raised as Christians and came of age in the Civil Rights era. I learned for four days under the guidance of Roshi Maull, and he made mention of "interoceptive awareness" and "interoception" as means by which to orient meditators' awareness of their interior milieu. For over a decade after beginning to practice sitting meditation at Harvard Divinity School, where I took a class with Glassman, I had committed myself to daily sitting practice. I began with a fairly basic practice of attending to my breath, experimented with body scans and somatic protocols guided by Reggie Ray, and then developed a practice rooted in postural forms of mindfulness like hatha yoga. I believed that my trip to UZC would allow me to experience the group meditation practices with others, deepening my connection to the physical place where my interviewees learned.

---

[2] My ongoing dialogue with Charles Taylor, *Sources of the Self: the Making of the Modern Identity* (Cambridge: Harvard University Press, 1989), especially 25-52, reveals my commitment to understanding the moral practices of late modern subjectivity through an expressive rather than critical mode. In contrast to Rose's position, see Taylor description about how self-articulating subjects position themselves relative to their conceptions of the good. He says, "Now we see that this sense of the good has to be woven into my understanding of my life as an unfolding story. But this is to state another basic condition of making sense of ourselves, that we grasp our lives in a *narrative*" (47). For an integration of these perspectives from the basis of a feminist critique of Taylor, see Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (New York and London: Routledge, 1998), 143-148. Feminism provides the recognition of social location that reveals the masking of marginalized social identities that limit the supposed autonomy of Taylor's self-articulating subject who composes himself in a quest for narrative wholeness.

As my visit to UZC made clear, Zen makes ample space both in the daily routines of practice and the ritual context to contemplate death and loss. The meditation of Zen students on suffering, death, and loss are foundational to the practice of Zen. UZC's daily ritual life in the Dokan-ji Zendo ends with Dogen's famous articulation of the value of death as the goads to the attainment of wisdom. The writings of Halifax herself point directly to the value of contemplation of mortality: death reminds human beings about the ontological truths of their organism. Ending the day with Dogen's chant, common to Zen communities, makes experiential knowledge of one's finitude the curator of wise living. In 2008, Halifax published *Being with Dying* as a sustained discursive meditation in the Zen style of contemplating how death reveals to medical caregivers the truths of their being. These teachings take on experiential vitality in the meditation practices of chaplains trained at UZC, in consonance with the legendary origins of Buddhism, which came about after Shakyamuni Buddha encountered old age, sickness, and death. His encounters with these existential realities embodied in suffering human beings prepared the prince Siddhartha Gautama to realize his own awakened nature as the Buddha. He took up the spiritual path embodied in the person of the fourth entity he encountered, a wandering ascetic.[3]

UZC is the place where each Zen chaplain begins to realize the mythic path of Shakyamuni Buddha in her or his own experience, a place where the role of the Zen chaplain is interwoven with their own personal mettle. In bringing together teaching and experience, these chaplains reinvent Zen in a neurobiological key, thereby crystallizing the medicalization of their own personal spiritual path. I discovered how the stories of my interviewees evoked the presence of the religious community of Upaya in their personhood. Our dialogues revealed horizons of meaning and generated new fields of relationship which I use here to interpret the practices taught at UZC and embodied by its students, particularly around mindful spiritual care and an understanding of that care that leans heavily on medicalized interpretation. In this endeavor I apply the methods of "person-centered interviewing" to reveal the roles and identities at play in American Zen clinical chaplaincy. By revealing horizons of meaning as general approaches and personal styles, "person-centered interviewing *generates* a field of new phenomena, of reports and behaviors, that are then subject to interpretation."[4] The position of the ethnographic researcher who applies contemplative methods to her own self-constitution as a perceptive embodied mind mirrors that of the chaplain, since the disciplines of both methods of paying attention prepare her consciousness to

---

[3] John Powers, *Introduction to Tibetan Buddhism* (Ithaca: Snow Lion Publications, 2007), 42-46. I have heard or read other versions of this story, but the version Powers tells has had the most lasting effect in my memory.

[4] Robert Levy and Douglas Hollan, "Person-Centered Interviewing and Observation," in *Handbook of Methods in Cultural Anthropology* 2nd Edition, ed. Bernard Russel (Lanham: Rowman & Littlefield Publishing Group, 2015), 317.

bear witness to the persons she encounters so that she can perceive them clearly. My role is to draw near to practitioners of mindful spiritual care in order to accompany them, resonate with them, and create a bridge between the meaningful worlds of Zen chaplaincy and a broader public. In this task, I see myself as a dialogical conduit between the world of the retreat center and the world of the personal practices of mindful spiritual care of Zen chaplains at play in diverse institutional contexts. It takes the basic empathy at the heart of interpersonal relationships to reveal and bear witness to and interpret these differentiated but articulating worlds in their complementary complexity.[5]

***

In late August 2018, Santa Fe received unusually steady rainfall. When I visited and commented on the verdant displays of the orchards and vegetable gardens, the director for UZC's chaplaincy program Petra Hubbeling told me that the steadiness of the rain was uncommon. The entire grounds were vibrant with green, as fresh grass pushed its blades up in the open, and weeds knifed in between the paving stones connecting the buildings that surrounded the zendo. The ecological qualities of UZC as a space of reciprocal spiritual care influences awakening. As member of the 2018 UZC chaplaincy cohort Miranda Mellis wrote in response to my question about the effects of UZC's physical and geographical setting:

> The beauty and calmness, in particular the intelligence and care put into the gardens, landscaping, paths, as well as the architecture, remind me that every detail deserves respect and matters, and invites appreciation for our lives and for the causes and conditions that allow us to be at Upaya. It makes me slow down and makes it easier for me to access wonder and joy, curiosity and hope.[6]

My personal interviews with UZC students convinced me that I could not understand the processes of maturation, discernment, and the cultivation of compassion in the chaplains I interviewed without visiting UZC to explore how the training context and Zen teaching styles informed the accounts of spiritual caregiving I heard during the interviews I conducted. After contacting Halifax on Facebook in early February, she quickly connected me with Petra, who communicated with the larger Upaya network. Halifax conveyed a confidence that continued research, even if critical, will reflect well on the institution she leads, and this is why I believe that she was so eager to connect me with others in the organization. When Petra announced my appeal for interviews to the online community, I received many generous offers from UZC chaplains eager to share their craft with me. Before I visited the weekend that Fleet Maull presented

---

[5] John van Maanen, *Tales from the Field: On Writing Ethnography* 2nd Edition (Chicago: University of Chicago Press, 2010), 80.

[6] Miranda Mellis, personal email, September 15, 2018.

his teachings on suffering, compassion, and wisdom in early August, 2018, I interviewed chaplains in UZC's network throughout the US.

Between February and November 2018, I conducted dozens of interviews with clinical chaplains across spiritual and clinical communities. The greater part of the interviews came from chaplains of various faith backgrounds, embodying diverse religious identities, who attended intensive retreats with Roshi Halifax. Their stories reveal the effects of the intersubjective contexts of communities of practice like UZC on the spiritual and vocational discernment of chaplains. In the practice of late modern spiritual care, the professional value that predominated in most interviews was compassion in its various guises. Broadly speaking, chaplains across institutional domains identify compassion as central to giving care. Context specific actions that vary by religious tradition might constitute compassionate action in religiously or situationally nuanced ways. For example, chaplains may enact compassion in different ways in hospitals, hospices, or prisons based on the histories or cultures of the institutions in which they practiced spiritual care. Protestant chaplains might practice compassion by saying prayers asking for God's mercy, while Buddhist might internally visualize Tara or another awakened being of compassion offering the sufferer succor. Though particular religious expression might differ, the desire to free others from their suffering and the motivation to take action because of suffering bears a strong family resemblance across late-modern institutional settings and religious traditions.

From numerous conversations with clinical chaplains who shared vulnerably with me, I came to understand the ability to act compassionately as at least partially enhanced by meditation practices. I came to see meditation practices, with which I had my own personal experiences in several contemplative communities, as responsible for extending the sense of self so that one could see others as having an intimate connection with that self. I could see how meditation practices like mindfulness and *zazen* might and often do enable meditators to perceive how their identity shifted and changed in close connection with the identities of other persons in interlinked relationships with them. In my work as a chaplain intern, volunteer, and resident, I could see the benefit of the contemplative chaplain's growing awareness of her interconnection with others. More than that, I began to perceive that the framework of Bernie Glassman's Three Tenets could be integrated into my methods of ethnographic study to enhance the clarity of bearing witness to the persons and their stories that I encounter as an ethnographer.

By the time I visited UZC, my research interests started to gravitate toward understanding how late modern clinical chaplains undertook two tasks. First, I sought to know how they cultivated a sense of "extended self" by the means of contemplative practices like mindfulness and

zazen.[7] Second, I sought to understand how this extended sense of self enabled them to enact caring responses even in situations of great personal and interpersonal distress. To understand in more detail how UZC trains Zen chaplains to generate compassionate responses through the cultivation of mindfulness, I will be retelling a series of stories about their caregiving work. I have used person-centered interviews to discover and explore these stories in greater nuance, focusing over time with increasing acuity on the connection between grief and compassion.[8]

In the process of conducting research, I slowly integrated textual study of the views expressed by American Zen teachers with person-centered interviews and my own interior experiences of similar processes. The interconnection of grief, spiritual maturity, wisdom, and interpersonal experiences began to emerge as my "particular research interests and developing sense of significant problems."[9] The transformation of grief into compassion often occurs in relationship to specific techniques adapted to enable the grieving person to free herself from the strangling grip of deep and dire emotions like fear, sorrow, and anger. Alongside these namable emotions are the subtle energetic flows that neuropsychological discourse names affects.[10] Both emotion and affect flood and destabilize a person's consciousness during grief. This instability of the self can lead to a clarification of values that reveal the self in relationship to role-bound social displays. Person-centered interviewing practices bring grief to light, highlighting the discrepancy between the view of a person as an informant and as a respondent. Informants describe the general social role that obtains in a community, whereas a respondent articulates the truth of hidden depths. A clinical chaplain might espouse a view of mindful spiritual care that promotes the prosocial acts in which they engaged, whereas a respondent might note their unexpected difficulty with hospital chaplaincy.[11] Darkness and confusion often appear in an unassuming guise.

In working with grief, clinical chaplains learn to enliven their practice through internalization of a stance of acceptance toward themselves and their experience. American Zen teachers like Fleet Maull stress that the basis of this feeling of unconditional friendliness is the basic human goodness that all human beings share regardless of social conditioning, social role, or social location. Before giving nuanced guided instruction, Maull writes:

---

[7] Joan Halifax, *The Fruitful Darkness: A Journey Through Buddhist and Tribal Wisdom* (New York: Grove Press, 1993), 4; Joanna Macy, *World as Lover, World as Self: Courage for Global Justice and Ecological Renewal* (Berkeley: Parallax Press, 2007), 157.

[8] Levy and Hollan, "Person-Centered Interviewing," 315.

[9] Ibid.

[10] Daniel Siegel, *Aware: the Science and Practice of Presence* (New York: Tarcher Perigee, 2018).

[11] Levy and Hollan, "Person-Centered Interviewing," 316-317.

> Mindfulness meditation naturally encourages a more accepting and compassionate stance toward ourselves and our moment-to-moment experience. Through mindfulness practice, we develop stabilized attention, mental clarity, and emotional balance, as well as an open, curious, and more equanimous relationship to ourselves and whatever arises in our field of attention. Furthermore, mindfulness allows us to experience what Buddhists call maitri in Sanskrit and metta in Pali, often translated as "unconditional friendliness" or "loving-kindness."[12]

Certainly the practice of an abiding sense of friendliness with oneself and one's experiences does not happen instantly. It is the outcome of a long, glacial process of change that meditation practice helps unfurl in one's consciousness and body over the long term. It is along the lines of the arduous process involved in making a state of mind into a character trait that can be consistently reproduced across social contexts. The practice of mindfulness like the concentrated listening at the heart of ethnographic study generates a field of interior and exterior relationships that bear the fruit of authentic insight. This intersubjective field has unique features and more general application.

Its current leaders hold that UZC enables chaplains to become aware of, regulate, and transcend the individual self in service to local ecologies. This is because UZC is an environment in which these chaplains can befriend their hidden depths. The physical space of the Buddhist abbey was curated—with Buddhas sitting in Native American style bean, corn, and squash gardens—to induce peacefulness and relaxation in the chaplains who make it their spiritual home. It is intended to stabilize the interior patterns of consciousness of each member, bringing more of the interior life in greater nuance into explicit consciousness while promoting thought and affect that extends conscious thinking and feeling beyond concern for oneself. The view of contemplative neuroscience, such a view proposed by David Vago and David Silbersweig, holds that self-transcendence requires both self-regulation and self-awareness as preliminary work.[13] In this work, mindfulness practice is an invaluable resource. In my engagement with the stories the follow, two questions guide my interpretation. First, how do Zen chaplains imagine the relationship between compassion and bearing witness to the suffering of others and how do they translate the means to develop compassion into clinical settings? Second, what new discourses and knowledges do chaplains use to constitute and reinforce their practices of cultivating values and how does their value cultivation reinvent the traditions these discourses embody? The tragic shadow of suffering animates each story presented here, only so much of which can appear in words and images. The effect of that suffering does not always display itself in the expected way—it retains an element of mystery and uniqueness that is hard to put to words. Halifax says, "we need suffer-

---

[12] Fleet Maull, *Radical Responsibility: How to Move Beyond blame, Fearlessly Live Your Highest Purpose, and Become an Unstoppable Force for Good* (Boulder: Sounds True, 2019), 176.

[13] David Vago and David Silbersweig, "Self-Awareness, Self-Regulation, and Self-Transcendence (S-ART): A Framework for Understanding the Neurobiological Mechanisms of Mindfulness," *Frontiers In Human Neuroscience* 6 (2012): 1-30.

ing in order to develop our ideal of compassion, for compassion arises from the darkness of human travail."[14] Yet each experience of the darkness of human travail can only partially find its way into language.

In my appreciation of the significance of UZC, two distinct pathways—the pathway to spiritual maturity and the pathway to embodied compassion—meet at the Zen center at the foot of the Sangre de Christo mountains in New Mexico. These two distinct pathways, which exert reciprocal influence on each other, symbolize the lasting effect of liberal religion in the United States, giving safe passage to spiritual seekers and liberal Protestants, Catholics, and Jews into UZC's community of mindful spiritual care. These two paths also have the practical effect of reinforcing and strengthening the interfaith dialogue of the late modern US context. First, chaplains trained at UZC believe that the program has allowed them to develop greater spiritual maturity and depth of interpersonal insight as elucidated by the disciplines of spiritual psychology and American Zen. This means understanding themselves to have an ability to interpret their inner states and relationships with greater sensitivity. Mindfulness practice shows everyday life's suffusion by transcendent yet ordinary interactions. Second, UZC's chaplains imagine that they embody moral frameworks by altering their neurobiological systems and enabling themselves to respond more compassionately to suffering. In both organic processes of self-cultivation, chaplain trainees perceive that other members of the community of practice at UZC are forceful agents of prosocial modeling. In the narratives my interviewees tell, UZC redirects the awareness of chaplains from the socially conventional notions of self that Zen Buddhists believe prevent chaplains from realizing their 'true self' to a self that feels deep resonances with all sentient beings. Thus UZC training reinforces the uniqueness of late modern selfhood while reinterpreting the quality of its inwardness. UZC chaplains do not practice mindfulness in an isolated inner milieu; they practice mindfulness in an inner milieu alive with the presence of countless unique others. This means that clinical chaplains trained in mindful caregiving see themselves as particularly well positioned to offer receptive spiritual care to others in pluralistic biomedical settings.

A Pathway to Spiritual Maturity

I interviewed Liz Farmer by phone the week before Thanksgiving in 2018. The sky's entire expanse was bright blue the way it can only be when very little humidity is in the air. The heavens had the luminescent look of blue crystal, and called to mind the metaphor for the open awareness of the mind made in Tibetan Buddhist traditions. Farmer is a middle-aged white woman from New England with an advanced degree in education. She spoke precisely and de-

[14] Halifax, *Fruitful Darkness*, 217.

liberately, with measured phrases in a calmly positive tone. She had a thoughtful, patient, and cheerful presence that balanced between appreciation and insightful criticism. She articulated trenchant social critiques of the racial dynamics of American Zen communities of practice that shifted into mildly self-effacing commentary about her personal and vocational life. She was both quick to laugh at herself or me and equally quick to point out some of the social inequalities that are a consequence of American Zen's history. Like notable historians such as Richard Hughes Seager, she was interested in naming how the lines of transmission from Asian dharma teachers like Shunryu Suzuki and Taizan Maezumi to students like Richard Baker and Bernie Glassman perpetuated racism. UZC has recently responded to the critical feedback of community members like Farmer about the predominant whiteness of the community by inviting two dynamic black lesbian teachers to counteract the whitening of the dharma in American Zen.[15]

Farmer and I began speaking about her prison chaplaincy a few weeks after we had collaborated on a panel at a conference entitled "Interdisciplinary Approaches to Mass Imprisonment" hosted by the Jefferson Scholars Foundation at the University of Virginia. As I sat nearby a Palatka holly on my grandfather's front porch, I gazed at its pronged evergreen leaves and bright red berries. Along with panel presentations by three other interfaith chaplains adapting contemplative practices of various sorts to prison ministry, Farmer had interviewed a steadfast group member of the prison mindfulness program she had been facilitating in Maine since she finished her training at UZC. Lauretta had just transitioned from the prison back into society, and Farmer's tone of voice betrayed concern for her friend's future. After a generous pause when I asked her about her chaplaincy training, Farmer indicated that one of UZC's greatest strengths was its ability to encourage the development of what Farmer calls "spiritual maturity."[16] Farmer spoke of the quality which marks "spiritual maturity" as the "magic of inner chaplaincy,"[17] evoking the muted everyday enchantment of American Zen. She seemed to mean that paying close attention to her inner world of motivations, feelings, and values would give a chaplain the ability to accept and work skillfully with herself whatever she might find. In her view, the intense and sometimes painful process of bearing witness that takes place in inner chaplaincy promotes self-compassion. This echoes a core teaching of Fleet Maull in the workshop I attended: that the coalescence of this ability to accept herself becomes the ordinary and miraculous staging ground for

---

[15] angel Kyodo williams, "Four Noble Truths: Simple Teachings for Extraordinary Times," accessed November 1, 2019, https://www.upaya.org/program/four-noble-truths-simple-teachings-for-extraordinary-times-2019/?id=2182; Zenju Earthlyn Manuel, "Embracing the Fullness of Emptiness," accessed August 20, 2019, https://www.upaya.org/2019/08/manuel-embracing-fullness-emptiness/.

[16] Anne Gleig, "From Theravada to Tantra: The Making of an American Tantric Buddhism?" *Contemporary Buddhism* 14 no. 2 (2013): 224. Gleig notes a similar emphasis on spiritual maturity at Spirit Rock.

[17] Ibid. In her study of Spirit Rock, Gleig names an emphasis on "spiritual maturity," but does not refer to the process of spiritual maturation as "magical."

a chaplain's skillful care for others. UZC chaplain trainee Melinda Mellis articulated it to me in this way:

> A central premise of Roshi Fleet Maull's workshop was that our capacity to attend to the pain and suffering of others as chaplains is dependent upon and proportional to our capacity to attend to our own pain and suffering. This feels very connected to the year of inner chaplaincy which new chaplaincy students are enjoined to embark on in our first year of the program. If we are to remain truly present as chaplains, we must remain truly present as chaplains for ourselves.[18]

The chaplain's ability to attune to self and other facilitates a chaplain's deepening sense of warmth for herself and her own life, which enables her to take compassionate action. In Farmer's experience the vast majority of her cohort completed UZC's program in what she describes as a more "spiritually mature place," which she witnessed herself, heard her classmates reflect on, or saw leadership notice and positively reinforce in others.

Because the entire first year of UZC's program focuses on intensive self-reconstructive work grounded in meditation practice, chaplains who finish its two-year program uncover the subtle inner workings of their own value structure, motivational dispositions, and their patterns of transference and countertransference. The inner work that chaplains complete in their first year culminates in *jukai*, which is a formal Zen ceremony recognizing the Zen student's integration of the fourteen precepts into her Buddhist identity. *Jukai* means "to receive" or take the fourteen Zen precepts.[19] For key cultural translator of Zen from Japan to the US Taizan Maezumi, the ceremony entails making "yourself one with the Three Treasures"—*buddha*, *dharma*, and *sangha*.[20] Richard Hughes Seager describes *jukai* in the late modern US context as "a formal rite of passage that marks entrance into the Buddhist community" and results in the student bearing a *dharma* name like Bernie Tetsugen Glassman.[21] The *dharma* name symbolizes the spiritual transformation undergone by the mind-nervous system-body of the Zen chaplain or teacher on whom it is bestowed. Spiritual maturity issues from deep knowledge of what Zen practitioners call the 'true self' as distinguished from the conventional self. The self-compassion at the heart of Zen awakening is a form of deep connection with one's hidden spiritual depths, which persuades Zen chaplains to trust the unfurling of their inner nature. Though distinct from each other, both selves are inextricably interlinked, which Zen holds to be true because all phenomena in the seen and unseen realms are integrated into one seamless whole. The realm of the absolute and the realm of

---

[18] Mellis, September 15, 2018.

[19] Taizan Maezumi, *On Zen Practice: Body, Breath, and Mind* (Boston: Wisdom Publications, 2002), 67-71.

[20] Ibid., 68.

[21] Richard Hughes Seager, *Buddhism in America* (New York: Columbia University Press, 2000): 109

conventional experience mutually interpenetrate—they are not two and not one. They are like the dark side and illuminated side of the moon, to which the finger of Zen has pointed since Buddhagosha brought Chan from India to China.[22] The interplay of darkness and light, seen and unseen, is integral to the art of Zen spiritual care. Zen teaches how to engage with one's fears and griefs in a way that leads to personal and interpersonal transformation in clinical and personal encounters.

UZC's chaplains actively choose to live by a rule that regulates their desires and behaviors, but spiritual maturation involves a complex negotiation between adherence to precepts and the felt quality of bodily experiences.[23] Wisdom reforms the heart. In joining other students who commit themselves to the precepts—both in their cohort and the ones who came before—UZC's chaplains constitute a society of Zen chaplains who accompany each other on an arduous path of service. The social symbolism of wearing austere new garments—the *rakusu* and black Zen robes—and a shaved head symbolize the chaplain trainee's entry into a second childhood. UZC's chaplains bear ritual markers of entering back into a malleable, gestational stage,[24] in which new imprints of affect and action can grow from the soil of the heart and mind freed from attachment to the conventional identities inculcated by mass society into the heart, mind, and body. Indeed, *jukai* ritualizes the body in such a way that it inscribes character traits of concentration, mindfulness, and equanimity into the nervous system, which leads to the reciprocal embodiment of receptivity. This ritualization empowers the bodies and minds of Zen chaplains as ritualized agents.[25] Thereby, the body and nervous system are potentiated for equanimity.[26] To practice not-knowing is to repeatedly reapply this pattern of openness and malleability that is first laid down

---

[22] Joshin Byrnes, "The Embrace of the Boddhisattva," January 19, 2019, https://www.upaya.org/2019/02/byrnes-embrace-bodhisattva/.

[23] Emile Durkheim, *Moral Education: A Study In the Theory and Application of the Sociology of Education* (New York: Free Press, 1961). Durkheim argues for the sociological examination of how morality encompasses the ethical categories of duty and the good. This discussion continues to be salient because of its recognition of the moral persuasion associated with the authority of teachers in the secular nation-state. Since learning in context requires that the student respond to the feelings his environment evokes, the teacher's moral authority is best described as an orienting force.

[24] Victor Turner, *The Forest of Symbols: Aspects of Ndembu Ritual* (Ithaca: Cornell University Press, 1967); I mean to evoke Turner's description of the liminality of rituals in which initiates become like infants again and communal solidarity arises after initiates lose the identity markers of a certain social location. Halifax's background as a Zen Roshi and medical anthropologist who has studied ritual systems amongst the Dogone and the Huichol undoubtedly endows her with practical and theoretical knowledge of ritual systems on three continents.

[25] Catherine Bell, *Ritual Theory, Ritual Practice* (Oxford, New York: Oxford University Press, 1992), 197-223.

[26] Daniel Goleman and Richard Davidson, *Altered Traits: Science Reveals How Meditation Changes Your Mind, Brain, and Body* (New York: Penguin, 2018), 98-99.

in the initial year of inner chaplaincy to the challenges of both professional and personal life. It is to bring *jukai* into one's ordinary, daily life. This is partial and piecemeal work, which takes a lifetime to bring to completion in the particular circumstances of social worlds.

Deep experiential knowledge of self and other in the context of friendship provides conditions ripe for growing and harvesting the fruit of lovingkindness and altruism. This insight begins with the understanding that all human beings can only be and become in interpersonal relationships. Such deepening experience of self/other often takes into account the social type of both self and other, working with the implicit biases one finds as constitutive of the socially conditioned mind. Seeing the conditioned responses as inherently intent on establishing false mastery, Zen intuits that all unconditioned selves are coequal and coeternal, the source of human and creaturely dignity. When a chaplain receives someone facing an existential threat, she is also greeting and supporting an aspect of herself. She is providing herself the internal means by which to reorient her own stance toward such a threat, which she will also eventually confront. She is actively lessening her own tendency to react against threatening events, by lifting to the fore her various options for action. Various experiences of social conditioning pertaining to race and gender impinge upon a chaplain's work in manifest ways, though often chaplains do not explicitly name the racial, sexual, or gendered dimensions of their social location in describing their work as caregivers.[27] Spiritual maturity means accepting and working with one's limitations and blindnesses, one's resistances, biases, and entrenched attachments with an openness to reforming them.

Spiritual maturity manifested itself in my conversation with Farmer about her process of discernment and ultimate decision to make slight adjustments to her chaplaincy path. She accepted the fact, while laughing at her own need for more long-term relationships, that she prefers not to work in the hospital setting. This fact surprised her, since she did not anticipate desiring to immerse herself in prison chaplaincy at the start of her clinical pastoral education internship. Responding to my question about what her motivation was for redirecting herself, she said that she found in her internship that the briefness of the interactions in clinical chaplaincy led her to long to know persons to whom she provided care in more depth. She located in herself the desire to know how the spiritual path of patients and families developed after her visits. In contrast to her experiences in a biomedical institution, Farmer has discovered to her surprise that penal institutions provide the ideal conditions for the development of relationships that take place over many

---

[27] Robin Diangelo, *White Fragility: Why It's So Hard for White People to Talk about Racism* (Boston: Beacon Press, 2018), 25, 56-57; Walker, *Moral Understandings*, 131-152. Among other dynamics that prevent open critique of white supremacy, Diangelo provides a description of normative whiteness as a basis for engaging in a critique of color blindness. The elision of gender in the moral philosophy of John Rawls, Bernard Williams, and Charles Taylor similarly provides the grounds for Walker's critique of normative "career selves" in moral philosophy.

years. Her current work in the Maine Department of Corrections has enabled intimacy and mutual support that unfolds within the context of spiritual friendship advocated by traditional Buddhist teachers.[28] In listening to Farmer, it occurred to me that for her, practicing self-acceptance means that the chaplain accepts her conventional self and its limits, while she maintains a strong connection with her spiritual depths. Because she accepts her mysterious inner nature, this leads her to acceptance of the limits and mysteries of others. It also means she has the power to challenge herself and others gracefully, sometimes even in moments of distress and confusion. Working with women prisoners in the Maine Department of Corrections, Farmer has come to value what she calls the "real reciprocity" she finds in the trust she feels with the group's women. Though she does not concern herself with attending to her own desires in managing the group, she cherishes the "intimacy that is created when you bear witness over time without judgement" to each other's joy and suffering.

In interpreting Farmer's narrative, one might question whether or not she spent enough time in clinical caregiving work to gain an accurate view of the reality of clinical chaplaincy. One could question the basis of her assessment. To what degree is this view idiosyncratic? Does it reflect the uniqueness of her personhood or does it reflect some form of attachment that she needs more experience to release? Bearing witness to her story does not obviate such considerations, but it counsels letting go of them to attend to how Farmer engages with her own inner world in relation to her vocational choice. According to Farmer, her experiences in the medical setting did not provide conditions that led to a growing sense of solidarity with others or herself. My greater point is that her way of interpreting her experience through the story she tells highlights an acceptance of herself and her views on prison chaplaincy's fit for her proclivities as a form of "spiritual maturity." Valuing this story as an example of spiritual maturation does not necessarily entail that I or any other conversation partner agree with her in part or in whole. It does invite one to accept the interior basis of Farmer's decision, her inner intuitive sense of herself, as a credible guide in her orientation and reorientation. Farmer recognizes her desire for intimate relationships with other people walking on what she sees as an authentic spiritual path. She sees herself as a spiritual friend who can bear witness to the steady steps of a group member's self-transformation like a faithful mirror, and the group can faithfully bear witness to and mirror her steady steps.

In the first year of her chaplaincy training, Farmer completed a clinical pastoral education internship at a local hospital in Maine. Her internship provided her with the clinical experience she used to discern which institutional context suited her. UZC's program gathers chaplains working in multiple institutional contexts into one curriculum, which allows trainees with a vari-

---

[28] See Chögyam Trungpa. *The Path is the Goal: a Basic Handbook of Buddhist Meditation* (Newark: Audible, 2014), chapters 10 and 11.

ety of experiences to trade views. The chaplains complete volunteer hours and typically also participate in clinical pastoral education programs concurrent to their training at UZC. Various experiences converge through the encounters between chaplains working in different institutions and in different geographic locations throughout the US, which is perhaps one of the most unique features of various American Zen spiritual care training programs. Buddhist chaplaincy programs promote this institutional diversity in a very intentional way, but it is also the case that many Christian chaplaincy training programs do the same. These Buddhist and Christian programs draw together chaplains from different institutional domains to interact and learn together. A distinctive quality about UZC's program is how it features extensive contemplative grounding, exposure to neuroscience frameworks, discussion of non-dualist Buddhist philosophies, and training in systems analysis, which attracted both Farmer and Jinji Willingham. No matter the institutional domain of UZC chaplains, they will know how to ground themselves in an embodied awareness that attends to thoughts, feelings, perceptions, and sensations as they arise and fall away in consciousness. Farmer's story shows how mindfulness practices develop a chaplain's embodied sense of awareness in relationship to others and an extended notion of selfhood that she can skillfully use to guide her vocational discernment.

The Three Tenets as Deep Listening

UZC reinvents the American Zen legacy of Bernie Glassman's ZPO by medicalizing the socially engaged Buddhism that Glassman proposed. The leadership at UZC has taken the basic three step framework of letting go, bearing witness, and acting in a contextually appropriate way and applied it to spiritual caregiving in clinical settings. American Zen students have applied the basic framework of Three Tenets to numerous social justice initiatives, the medicalization of the Three Tenets is but one particular form of its translation to a secular context. Along these lines, Halifax, Petra Hubeling, Joshin Byrnes and the other leaders of the chaplaincy program at UZC have designed the chaplaincy curriculum to begin with grounding in *zazen*—the Three Tenets being an Americanized version of the Zen forms of sitting meditation. Farmer says that Halifax directed all chaplains in the UZC program to commit to at least twenty minutes of practice daily. This is a common approach in Zen, which is noticeable at any Zen retreat center. Any given day at UZC begins and ends with at least thirty minutes and up to an hour of sitting meditation, interspersed with walking meditation, and movement practices like hatha yoga and chi gong. The day closes with a reminder of human mortality and the preciousness of human birth. The fall of night is punctuated by the chanting of Dogen's famous admonition, which highlights the experiential truth of impermanence.

> Life and death are of supreme importance –
> Time passes swiftly and opportunity is lost –
> Let us awaken –
> Awaken . . . Do not squander your life.[29]

UZC trains chaplains in the ritual space of Dokan-ji Zendo, supported by a statuary embodiment of the Manjushri on the altar—golden and gleaming—and a painting of Green Tara on the western wall. The staccato chant that urges remembrance of human finitude likewise draws attention to the quest to embody the path to awakening that the Buddha taught and these various symbolizations of the buddhas manifest. The sanctuary beckons chaplains to connect to inner experience. It directs them to focus on their inner world while at the same time giving them the means to observe their impulses and emotional triggers without acting on them. The training and the ritual space work together to urge them to sit in stillness and pay attention to themselves. They pause, reflect, and let go of whatever is coming up in them in order to bear witness to what takes place in their body, extended nervous system, and mind.

American Zen teaches that the first step in sitting meditation is to let go of whatever thoughts, emotions, sensations, or perceptions enter the meditator's awareness. Glassman has made 'letting go' the iconic point of departure in American Zen ways of life. Chaplain trainees let go of the mental bundles that form the content of their minds and return to the open luminous space of consciousness. Numerous chaplains referred to the Three Tenets of the Zen Peacemaker Order (ZPO) as an adaptable means by which to ground themselves in their experience before and after visiting patients and families in clinical settings. UZC carries on this practical legacy of the ZPO. For example, palliative care chaplain Daria Bangler explains the value of the Three Tenets:

> Since I finished training at Upaya, I am steeped in the Zen Peacemaker Order's three tenants: not knowing mind, bearing witness, and compassionate action. So I prepare myself by saying I don't know what is going on. I may have some of the backstory, but I hold the story lightly. I attend to what presents itself to me when I am meeting with patients. I don't get hung up on agendas, not those of others or my own.

Letting go in order to bear witness to the patient's experience means that chaplains hold their agendas and backstories lightly. In this practice, mindful spiritual care as a form of self-regulation entails the relaxation of self-interest in order to attend to another's needs and desires. Bangler's application of the Three Tenets to her work as a part of a palliative care team in a large university research hospital in the Southeast speaks to the portability of Glassman's framework

---

[29] I wrote the lyrics for the night chant in my notes from the retreat led by Fleet Maull in August 2018. See also, "The Night Chant," Upaya Institute and Zen Center, accessed on December 5, 2018, https://www.upaya.org/2014/09/night-chant/.

for spiritually grounded responses to social suffering. UZC's training program for chaplains encourages chaplains to integrate such frameworks into their chaplaincy practice to orient themselves internally as they make their rounds. The integration of the Three Tenets into clinical chaplaincy work exemplifies Bernie Glassman's continuing effect on the socially engaged forms of Zen Buddhism taught at UZC.

The Three Tenets are the central spiritual practice in place in various social institutions associated with Glassman, which enable these communities to respond creatively to challenges in ways that are context specific. Interviewees who trained at UZC refer back to the Three Tenets with regularity to explain their method for engaging in chaplaincy work. Like a spiritual ballast, the Three Tenets—1) not-knowing, 2) bearing witness, and 3) situationally appropriate action (compassionate response)—afford chaplains the means to shape social and psychological conditions, so that compassionate action is more likely to arise as a response to an encounter with suffering. First, the chaplain practices not-knowing, which means that she "gives up fixed ideas" about herself and reality.[30] In essence letting go requires a chaplain to identify that thinking, feeling, narrating, or some other operation of self-interested cognition or affect has distracted her from anchoring in her awareness of the breath in the present moment. She then lets go of her discursive mind and places her attention on her breath again. In the language of interpersonal neurobiology, she is disabling the brain's "top-down processing" networks, networks which constrain choice by leading the brain to perceive current realties in terms of past experience.[31] The chaplain is providing the means by which the nervous system can engage "bottom-up processing" networks beginning with the five senses and perception of one's internal milieu.

Second, once the ground for perception of internal and external reality is not constructed predominantly by the scripts and stances of past experience, once the meditator is actively disengaging from past experience, evaluative frameworks, and dispositional sets, the meditator frees herself to bear witness in order to understand deeply what she is experiencing in the current moment in relation to others persons and beings in her current social context. The chaplain "decenters" and recovers the ability to see the self as more than narrative self-interpretations, memories, or

---

[30] Upaya, "Roshi Bernie Glassman," November 29, 2018, https://www.upaya.org/people/bio/roshi-bernie-glassman/; Halifax, *Standing at the Edge: Finding Freedom Where Fear and Courage Meet* (New York: Flitiron Books, 2018), 38; Mikel Monnett,"Developing a Buddhist Approach to Pastoral Care: A Peacemaker's View," *The Journal of Pastoral Care & Counseling* 59 no. 1-2 (2005): 58.

[31] Dan Siegel, *The Neurobiology of 'We': How Relationships, the Mind, and the Brain Interact to Shape Who We Are* (Boulder: Sounds True, 2011b), Chapter 5, Audible.

projected aims.[32] When the Zen chaplain bears witness in the freedom of the mind's luminous open state, Zen holds, she can perceive with clarity the unique nature of each encountered entity.

These first two moves of letting go and bearing witness bring the body and mind into a state of quiet wakefulness, from which, according to Zen, compassion naturally arises. That is, situationally-aware actions that arise out of bearing witness tend to be "an appropriate response"—a compassionate response.[33] Glassman's language of bearing witness echoes the position of Thich Nhat Hanh on mindful observation. Nhat Hanh proposes: "Mindful observation is the element which nourishes the tree of understanding, and compassion and love are the most beautiful flowers."[34] Nhat Hanh maintains that a chaplain's love for herself and for others cannot begin and end in her imagination but entails a physical embrace—the action of loving others. The mindful chaplain embraces others with an abiding presence, body to body and mind to mind, and does her best to maintain this presence when she wants nothing more than to flee. She listens to others in a reliably responsible way, practicing care and concern, living with them in communities of mindfulness practice. When she fails, she recovers herself, shows compassionate forgiveness for her limitations, and tries again wholeheartedly to embrace what she encounters. The inner dimensions of attending to the self and other with stillness and peace brings about a necessary shift in external relationships: sowing the seeds of greater peacefulness and compassion. Appropriate responses, broadly speaking, tend toward service of others, an inconspicuous altruism, and compassionate actions taken in solidarity. Zen chaplains make inconspicuous everyday compassionate responses to the suffering they encounter in their social networks, repairing in small and subtle ways the interpersonal and spiritual harms that compound suffering.[35]

Bearing Witness as Humility in Interfaith Dialogue

Halifax, Maull, and Glassman have produced forms of Zen practice that respond to the needs of seeker spirituality and religious liberalism for openness to religious multiplicity. The first two steps of the Three Tenets provide solid grounding for interfaith dialogue in the setting of inter-

---

[32] Vago and Silberswieg, "Self-Awareness, Self-Regulation, and Self-Transcendence (S-ART). A Framework for Understanding the Neurobiological Mechanisms of Mindfulness," *Frontiers In Human Neuroscience* 6 (2012), 23-24; Kirk Bingaman, "Incorporating Contemplative Neuroscience and Mindfulness-Based Therapies Into Pastoral Care and Counseling: A Critical Correlational Method." *Pastoral Psychology* 65 no.6 (2016): 769.

[33] Halifax, *Standing at the Edge*, 40.

[34] Thich Nhat Hanh, *Peace is Every Step: The Path of Mindfulness in Everyday Life* (New York: Bantam Books, 1991), 84.

[35] Daniel Siegel, "Toward an Interpersonal Neurobiology of the Developing Mind: Attachment Relationships, 'Mindsight,' and Neural Integration," *Infant Mental Health Journal* 22 no. 1/2 (2001): 79.

faith chaplaincy training and service, which has become one of the hallmarks of late modern spiritual care.[36] Besides preparing a clinical chaplain to skillfully engage in the suffering she encounters in a clinical setting, the Three Tenets also provide a means by which chaplains can engage in receptive dialogue with the beliefs and practices of others in chaplaincy training cohorts. During her Clinical Pastoral Education (CPE) internship and residency at BayCare, a fifteen-hospital health system in the Tampa Bay Area, the Three Tenets served Daria Bangler well in the estimation of her CPE supervisor Miguel Santamaria, whom I interviewed along with Bangler in June of 2018. Santamaria, who supervised me during my CPE internship in the fall of 2011, is a Presbyterian minister who was raised as a Catholic in Bogota, Columbia. He trained as an engineer before attending seminary and then training as a CPE supervisor at Tampa General Hospital, a well-known CPE training program in Florida. In his two years working with her, Santamaria appreciated Bangler's spiritual maturity. He attributed this maturity to her rich life experiences and her consistent meditation practice. He made the point that supervisors gain tremendous insight when they facilitate spiritual care discussions that involve trainees who know themselves well. Such discussions, in which supervisors and residents challenge each other to grow in an interfaith context, have led Santamaria to mature spiritually alongside spiritually maturing chaplain residents. He most especially values encounters with students from non-Christian backgrounds who challenge his own views in the context of interpersonal rapport.

The presence of spiritual maturity in chaplain residents gives a supervisor the possibility to nourish authentic relationships that lead to greater insight about caregiving across religious traditions. Santamaria made the claim that when supervisors get "a sense of spiritual maturity" in students, they feel "it is a gift" for them to celebrate with the student. He says that CPE supervisors feel rewarded by their relationships with students who have attained spiritual maturity because these residents can share insightful religiously-inflected perspectives on chaplaincy work with their supervisors. These divergent perspectives might not occur to the supervisors by virtue of the difference in their theological or philosophical starting points. Santamaria cites a saying of his spiritual director that explains his gratitude when receiving spiritual nourishment from the students he supervises. "I am a beggar," he smiled, "teaching others where to find bread." Santamaria's intense curiosity about Bangler and other students who come from non-Christian backgrounds reveals an openness to the religious and spiritual experiences of others that embodies religious liberal ideals. I would submit that this open curiosity comes from a sense of security in his own liberal Presbyterian religious identity—an ability to feel challenged by otherness without losing his bearings. Willing to explore in a mutually beneficial way by trying out the views of his

---

[36] Wendy Cadge, *Paging God: Religion In the Halls of Medicine* (Chicago: University of Chicago Press, 2012); Winnifred Sullivan, *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014).

student, Santamaria embodied the values of supervisory welcome and receptivity. A supervisor with the ability to suspend his knowing, or his "arrogance," as Santamaria was fond of calling his intellectual overreach, provides the right conditions for establishing a stronger "supervisory alliance." It was this capacity for curiosity and welcome that Bangler was pointing to when she said of Santamaria that "Miguel lives his values." As best he could, Santamaria embodied an ethic of interfaith welcome.

Specifically, Bangler remembers Santamaria helping her develop a theological framework and find language that would fit with her non-theistic, Buddhist views. Early in their collaboration, Bangler asked Santamaria, "Can you work with me?" The key shift was to think of theology and "theological refelction," as a particular Protestant version of the more general concept of "belief system." From that shared understanding, Santamaria and Bangler could begin to adjust the verbatim process (in which chaplain residents report on their interactions with patients to their peers) with the understanding that they would organize the case study approach around beliefs about reality rather than beliefs about God per se. Bangler referred to her interaction with Santamaria using the idiom of tinkering: "We tinkered with language for the verbatim based on the language of belief system in the place of the language of theology." Beyond instituting a change to the residents' documentary process, Santamaria's willingness to tinker with language and the verbatim form symbolized a greater willingness to openly amend his supervision, program, and educational process to accommodate a Buddhist student. The value of welcome translated into practices of curiosity—asking questions about the Buddha's teachings—and accommodation—collaborating with Bangler on revising language to reflect a non-theistic outlook. The productive interactions between Bangler and Santamaria grew out of the willingness of both to come to their relationship and process of mutual education with openness, engaging in form of "expressive-collaborative ethics of responsibility," an ongoing "negotiation *among* people, a practice of mutually allotting, assuming, or deflecting responsibilities of important kinds, and understanding the implications of doing so."[37]

This is the hallmark of religious liberalism, which continues to inform chaplaincy practice in the late modern world. Bangler and Santamaria's roles are characterized by a marked power differential, but each has mutually influenced the other's perspective on the identity, relationship, and values implicit in the moral practice of spiritual caregiving.[38] Openness and curiosity are attitudinal stances toward one's experiences, others, and the world that allow for continual learning and situation-specific responses. They are also embodiments of values that have a particular af-

---

[37] Walker, *Moral Understandings*, 61; see also Cadge, *Paging God*, 204; and Margaret Mohrman, "Ethical Grounding for a Professional Hospital Chaplaincy," *Hastings Center Report* 38 no. 6 (2009), 6.

[38] Ibid., 109-115.

fective quality in the body, reinforcing somatic modes of attention that induce the quality of softness or tenderness, which in turn promote interactive, reciprocal communication. That is, the dialogue between Bangler and Santamaria symbolizes how embodied dialogical communication constitutes intersubjective moral processes and practices. One becomes tender towards a trusted other that one begins to see as coequal to one's self. In this vein, Thomas Csordas comments on how the phenomenology of perception collapses the subject-object distinction, and this ambiguity extends to the notion of body-mind and self-other as well. Since the human body is the medium in relationship with which the extended nervous system conveys impressions about the world, the body as an object of perception and objects perceived through the body are constitutive of mental processes. Neuroscientist Antonio Damasio says it this way, "when the brain maps the world external to the body, it does so thanks to the mediation of the body."[39] Bodies are never solely objects but always serve as mediums of perception that "may become objectified through process of reflection."[40] Similarly other human beings in their bodies, "tear themselves away from being simply a phenomenon in my perceptual field." Just like one's own body, "other persons can become objects for us only secondarily, as the result of reflection" but rarely in dialogue.[41] Bangler and Santamaria became self-differentiated yet closely interconnected, unique persons who shared values and relationships in a mutually perceived community of care.

Others who exist in the "dimension of intersubjective being, and so offering the task of true communication" surprise the Zen chaplain, knocking her from her high horse and offering her unexpected challenge or grace.[42] To wit, Bangler narrates a story in which Glassman modeled the value of open-minded questioning in a dialogue with a student. Glassman listened to a thorny and verbose question, then asked, "'So basically what you're asking me is, 'what do you do when you don't know what to do?' Is that right?" The questioner nodded in affirmation. Glassman responded, "Rejoice, and praise your lucky stars." Bangler remarks on the atypicality of this response in our late-modern US culture: "Our society is not used to giving that answer. It is contrary to our patterns." UZC creates a sacred interfaith space that welcomes liberally minded chaplains and other stakeholders in medical and spiritual care who translate spiritual practices across institutional boundaries while engaging with persons who embody different religious commitments. This stance of open-minded humility on the part of Zen chaplains reflects the sim-

---

[39] Antonio Damasio, *Self Comes to Mind: Constructing the Conscious Brain* (New York: Pantheon Books, 2010), Chapter 11, Audible.

[40] Thomas Csordas, "Somatic Modes of Attention," *Cultural Anthropology* 8 no. 2 (1993): 149.

[41] Ibid.

[42] Ibid.

ilar liberal dispositions of chaplains of other faith traditions who practice spiritual care in late modern medical institutions.

Loss and Transformation

Before making a commitment to complete UZC's training for chaplains in 2014, Bangler volunteered in the Southern Dharma Center, which she indicated was the beginning of her mindfulness practice. Doing work practice in the kitchen provided her with the beginnings of an everyday contemplative practice not confined to sitting meditation. Up until she decided to commit herself to joining a community of practice at the retreat center, Bangler worked in the publishing house of a reputable southeastern research university. She identifies her stint volunteering at Southern Dharma, from 2009 to 2012, as the beginning of her spiritual path. After she left Southern Dharma in 2012, she entered the training cohort at UZC. Bangler's sense of spiritual calling as a chaplain sprang from the simplicity of attentively cutting carrots and instructing volunteers to do likewise. She remembers how her instruction for chopping vegetables at first appeared to dampen the joy in the experience of cooking for volunteers. She used to say in stark declarative sentences with concurrent demonstrations, "'You cut the carrots just like this.' And they would sometimes seem discouraged until they saw how their piece came together with the greater whole." As she told me the story, I could imagine the austerity of the simple kitchen, and the pivoting emotions of the volunteers, from drudgery to joy, once they settled into their task.[43] She continued, "In the beginning, the volunteers couldn't see how what they were doing fit into a greater whole, but with patience the work they did produced something really magnificent. It was a time of really putting the dharma into practice." The journey of a thousand miles begins with one small step. Could one argue that cutting carrots in a contemplative mode is a moral practice, a form of mindful spiritual care?

A similar process of ripening and deepening that is the hallmark of spiritual maturity can be seen in the life story of Linda Atkins. Atkins is a middle-class white woman with a college education who has the bearing of someone who works in a law office. As Atkins spoke to me on the phone a few weeks after we met at Maull's retreat, a characteristic high tone of excitement would enter her voice when she reached an emotionally salient moment. In the 18 years before her decision to become a chaplain, Atkins worked at Wells Fargo Bank. In 1990, she joined a *sangha*, that now goes by the name Mission Dharma, started by Howard Cohen, a *dharma* teacher who received his training at Spirit Rock. Exactly a week after the terrorist attacks on September 11,

---

[43] The experiential source of my imaginings here is volunteer work I have done at the Saint Francis House during high school (1993 - 1994) as well as the Haley House as the service practicum for Glassman's Zen Peacemaker Order class at Harvard Divinity School (2009). In my experience the apprehensiveness when beginning to serve tends to give way to the relaxation of serving within any community setting.

2001 she began to sit on a daily basis, missing only one day between then and the date of our interview on October 2, 2018. She directly connects the terrorist attacks at the World Trade Center with her felt experience of unmanageable fear. Around the same time she joined Mission Dharma's *sangha*, she completed a year-long course on chaplaincy taught at the Institute for Buddhist Studies (IBS) in Redwood City, California that based its approach on the *paramitas*. After finishing the course, Atkins felt an irresistible force motivating her to involve herself in chaplaincy. She has always imagined fulfilling her call in a clinical setting. Prior to beginning chaplaincy training, she felt herself wanting more capacity to serve with her whole self while volunteering at a local soup kitchen as she continued to work in the bank. She kept finding herself thinking about chaplaincy work and then joined the IBS class after it became clear her desire was more than a passing fancy. When she completed the course with IBS, Atkins joined a CPE internship and then a residency program at the University of California at San Francisco, completing four units of training there before entering UZC's chaplain training program. She went to UZC in order to receive the 'theological training' needed to become board certified as a clinical chaplain.

Reflecting on her professional reorientation, Atkins says she enjoyed the financial security of her career at Wells Fargo and little else. "I never felt great about working at a bank," she related to me. Especially after the course at IBS, she sensed a glacial shifting in her motivation. She afterward promised herself, if given the opportunity, she would begin a new career. She said to herself, "if these people lay me off, I am going to be a hospital chaplain." As she humorously quipped, "They did keep their end of the bargain. So I kept mine." While her story made me laugh with amused bitterness at her turn of phrase, I noted how the sharpness of her tone communicated a muted and faded anger alloyed with resignation and perseverance. I felt her tone awaken similar echoes in me of frustration, resignation, and perseverance when facing personal challenges because of decisions made by large bureaucratic organizations. She continued, "So, the minute they laid me off, I applied to CPE programs. Basically since that moment, I have felt like there is a powerful river that is carrying me along. It was absolutely my intention to be a hospital chaplain and to do everything I can to be a good one." Atkins identifies as a member of a Theravadan community of meditative practice, which bases its approach in the *Four Foundations of Mindfulness*, though as historian of religion Ann Gleig points out, Spirit Rock has an expansive and inclusive stance toward both late modern scientific disciplines like psychology and other meditation traditions.[44] Spirit Rock has intensified the modernizing trends already present in the translation of insight meditation into the American context. As no Theravada Buddhist community offers a training program that provides the requisite formalized education for ACPE credentialing, Atkins decided to complete training at UZC. She is working part time at the Uni-

[44] Anne Gleig, "Theravada to Tantra," 224.

versity of California San Francisco, while she volunteers at Zuckerberg San Francisco General Hospital to fulfill volunteering program requirements for UZC.

These stories highlight a paradox that clinical pastoral education programs squarely address through their curricula: human persons and communities avoid experiences of death and loss, but experiences of death and loss lead to great spiritual transformation.[45] Halifax frames this paradox in *Standing on the Edge* as such: if one avoids experiences of the dark mud of the bottom, one will not experience the lotus bloom of joy, freedom, and unconditional fearlessness (No mud, no lotus).[46] In a psychological description of this Zen aphorism, she refers to Kazimierz Dabrowksi's term "positive disintegration," which she defines as "a transformational approach to psychological growth based on the idea that crises are important for our personal maturation."[47] She elaborates further, "edge states are where great potential resides, and working skillfully within these states, understanding can be quickened."[48] That is, Farmer, Bangler, and Atkins have gained a measure of freedom in the way each woman has responded in times of loss and transition. These vocational pathways have led them at one time or another to care for others in situations of acute suffering within late modern medical institutions. Yet in certain stories, the loss is more personal. In these circumstances the grief is perhaps more poignant, but the emergence of personal and vocational values as the motivation for caregiving action is nonetheless preeminent in how a chaplain frames her narrative. For example, many chaplains I interviewed related stories about how the loss of a marriage or a child or both triggered the process that revealed to them what they value most. Here the suffering of grief is an unwelcome guest who nonetheless brings precious gifts. They tell their stories as a way to remember and share what they hold to be meaningful. In these stories, one can hear an echo of the fragility of human bodies and relationships and the anguish that results from the crumbling of family and community. In the event that a chaplain narratively remembers her world crumbling as a precursor to chaplaincy work, the experience of loss and suffering often motivates the desire to serve others who face similar losses. In this instance, the hidden and unfathomable depths hold an alchemy that transmutes pain and suffering into intimate connection through empathy.

In a way that exemplifies the power of suffering to motivate service, the story of Jinji Willingham speaks to the intersection of vocational and personal life in the values and motivations that inspire chaplains to undertake chaplaincy training. It is a testament to the revitalizing forces of grief and loss in spiritual maturation, the mud that nourishes the lotus bloom. Her decision to

---

[45] See Chapter 1 (page 30) for an elaborated view on this paradox.

[46] Halifax, *Standing at the Edge*, 5-6.

[47] Ibid., 5.

[48] Ibid., 6.

enter the vocation of spiritual caregiving came after the death of her young son Keeton in 2001. Describing herself before she took up a Zen path, Willingham said, "In my twenties and thirties, before the death of my son, I was largely dissociated from somatic and emotional experience. Keeton died when I was in my early forties. Through that loss I felt more integration in me. I was more alive and present, and I began to sit zazen." From 2004 to 2006, she started to sit in meditation with others at the Austin Zen Center, and attended a series of teachings given by Stephen Bodian.[49] Enticed by Bodian's no-nonsense style of spiritual guidance, she attended another series of his teachings from 2007 to 2008. After reading a short article of Nhat Hanh's in the beginning of 2008, she discovered she felt a strong connection with Nhat Hanh's Plum Village Sangha. Her divorce from her husband followed on the heels of the painful shifts in her orientation to herself, her community, and her spiritual path that grew out of her mindfulness practice and her affiliation with Zen.[50]

To punctuate the divergence between her newly emerging spiritual path and her life with her former husband, Willingham told me a story about her response to a man they both encountered who was living on the street. She narrates the story as if she were alone, a telling signal to me of the growing fissure she felt with her then husband. Her way of telling the account has a haunting and lonely quality. "One night on my way home, I saw a homeless man on the median. I looked into his eyes, and I felt very strongly that I could have been him." I could hear her voice go shaky as she brushed aside tears. She did not sound like she was suppressing her sorrow, but rather she was letting her shaky voice rebalance itself and the sorrow pass. "I remember thinking to myself that I could have been him. I spoke with my husband about what happened, and we actually got into an argument." The experience signaled the ending of her marriage to Willingham in a way that was not entirely clear in that moment despite its clarity in hindsight. It also signaled the beginning of a spiritual path that entailed bearing witness to the pain and suffering of others. Soon thereafter she entered a counseling degree program at St. Edward's University in Austin. Spiritual maturity points to an acceptance of the suffering of loss and grief in order to feel compassion for oneself and for others and these inspirations soon motivate compassionate action. After the death of Keeton and the disintegration of her marriage, Willingham said "I began to try to live from my heart, which led me to social engagement and community work." Along with what she was learning in her counseling program, she found that Zen similarly focused on interpersonal attachment and attunement to others. Zen reinforced a healthy sense of interdependence and connection.

---

[49] See, for instance, Stephen Bodian, *Beyond Mindfulness: the Direct Approach to Lasting Peace, Happiness, and Love* (Oakland: Non-duality Press, 2017).

[50] The loss of a romantic partner figures in the personal-vocation narratives of Jinji Willingham, Julia Lipschutz, Rob Adrian, and Matt Nettles.

Willingham, who completed UZC's training between March 2016 and March 2018, decided to apply to UZC because of the programmatic inclusion of attachment neuroscience and systems theory research in a Zen community of practice. She says that she "went to Upaya and fell in love with the experience"[57] she had there. She integrated her previous training with the frameworks she learned in UZC's program. "It seemed like a culminating moment or experience for me," she said, "because I had done so much training in systems, mindfulness, and attachment neuroscience. I had been practicing Zen for many years."[51] Willingham's story brings to mind the Zen aphorism "no mud, no lotus" because she found in her tragedy the motivation to heal herself and others. She entered into caregiving relationships with vigor to cull from loss the many fruits of spiritual maturity. For her this means revisiting suffering and loss in herself and in her relationships to those she serves in a way that pivots on her ability to empathically resonate with them. She feels the resonances of pain in those she serves and wishes them to be free of their suffering and its root causes. For Willingham, spiritual maturity means knowing how to encompass as much of experience as possible and use it for meaningful purposes, even the shadow sides. It also means knowing her limits, times when she stands at the edge of precipitous fall into the disintegrated chaos of overcommitment. For her, it means recognizing that her "life has certain cost," and that she needs to balance her own wellbeing with the wellbeing of the others she serves. When a chaplain like Willingham loses a child or a lover, the event fragments her personal identity and interpersonal world. These losses catalyze a process of self-transformation, taking place in the perceptual field of the body, by which Zen chaplains reconstitute themselves and their lives through compassionate action that heals the painful memories of the past while serving the needs of patients facing similar losses.

The Limits of Altruism

Willingham speaks with a frenetic vitality that communicates bustling ideas and a sense of intellectual vibrancy. She admits that part of her core identity is the tendency to involve herself in many projects, too many projects, which comes across in the overflowing of her speech. Towards the end of our phone conversation in May, as I sat out on coffee shop patio scribbling notes furiously, moving about as the drizzling spring rain made the ink of my pen run, Willingham brought her attention to a consideration of Roshi Halifax's newest book *Standing on the Edge*. She confessed, "My edge is that I have a hard time pacing myself. I have a tendency to

---

[51] Michelle Nicole also pointed to the integration of systems theory and cognitive and affective neuroscience into chaplain training as an attractive feature of Upaya's program. What Willingham is calling attachment neuroscience is the interpersonal neurobiological frameworks made popular in Daniel Siegel's imaginative the blend of psychiatry, attachment research, neurobiology, and mindfulness practices. Willingham named Siegel as a formative influence for her.

pathological altruism, where I am giving too much of myself and not attending to what I need to maintain myself. My life has a certain cost, and I can tend to neglect that." Halifax warns against harmful help, the kind of altruism that leads to "spiritual materialism"—a term coined by Chögyam Trungpa to describe the tendency for those walking a spiritual path to collect spiritual capital in order to display that capital to others on a similar spiritual path.[52] The action of helping can be self-serving, a way of demonstrating a kind of dominant identity that only cares about serving the interests of a community or society as a proximate good to its own self-aggrandizement. The pathological altruist serves the greater good in order to collect recognition and acclaim, while confining those she helps to a marginal identity that is the necessary complement to the privileged identity she craves.[53] Trungpa's argument points out the subtle dance between the ego-self, attuned to social hierarchy, and the unconditioned-self that knows heartfelt interconnection with all sentient beings. Even in the midst of a fully awakened life, the concern for self-advancement in social contexts can co-opt a deepening spiritual quest. By engaging in numerous altruistic projects, a chaplain may prove her spiritual superiority vis-a-vis peers she makes appear inferior through her actions, peers who obviously do not care enough about others to exert themselves as greatly as she does on behalf of all sentient beings.

Sociologists have long marked persons who act as intermediaries and whose social role has a purpose that extends beyond themselves and serves society as beings assigned a kind of moral authority. Emile Durkheim persuasively argued more than one hundred years ago that moral authority rests in the hands of teachers, who, like the priesthood of the Christian churches, intermediate between a transcendent reality and the persons in need of formation. Durkheim reasons that the teacher "is an instrument of a great moral reality which surpasses him and with which he communicates more directly than does the child."[54] In his view, teachers have moral authority because they touch a transcendent reality—the spirit of society—while performing a function that serves society at the cost of personal sacrifice. Their service to society makes them perceived as sacred vessels, conduits by which the transcendent realities pass into the minds and hearts of those who receive instruction. Halifax points out that in the contemporary social moment, a similar social preference remains in force, and she shows some self-awareness in naming her tendency to accede to socially dominant identities in her own spiritual life. This phenomenon is known as the altruism bias. "This is the social, cultural, and spiritual expectation to be empathetic and caring. Many of us are biased toward acting altruistically even when it might not be

---

[52] Halifax 2018, 29.

[53] Walker, *Moral Understandings*, 148-150. Every "dominant identity" requires the creation of its inverse, marginal identities deprived of social esteem.

[54] Durkheim, *Moral Education*, 155.

appropriate to the situation."[55] Halifax recommends a simple remedy for the tendency to engage in misplaced altruism, first grounding oneself in mindfulness, and then repeatedly asking oneself if one's actions serve. Does one's service actually provide the right remedy for social injustices or does it merely serve one to accrue more spiritual capital? This is a question that indexes an awareness that Willingham is living into through her interactive dialogue with Halifax, who serves as teacher, friend, and living exemplar of American Zen.

***

Spiritual caregiving and mindfulness practice in tandem render Zen chaplains more aware of their shadow sides, because they come to know their fragility and vulnerability. They also discover behaviors they have the habit of enacting to avoid pain, loss, defeat, etc. These vulnerabilities appear once interpersonal rapport stabilizes the affective tone of the relationship between the interviewer and interview, the chaplain and the patient. In each interview that explored grief, the interviewees revealed their own vulnerability when I showed my more vulnerable side. Once they knew that I had a commitment to vulnerable sharing—I presented myself as a "vulnerable observer" bearing witness to their pain and suffering—they themselves were willing to share vulnerably with me.[56] Each interviewee began speaking to me about UZC's chaplaincy program and Zen philosophy more generally, but they shifted into personal stories of loss when I spoke with sorrow about my separation and divorce or my confusion about how to find a vocation that fit my gifts and skills. I shared these feelings when chaplains asked me, as they are wont to do, about how I was feeling or what I was experiencing in my own life. When chaplains responded in kind by showing me their sorrow, I interpreted their response as an acknowledgment of my status as a fellow wounded storyteller, to use Arthur Frank's apt adaptation of Henri Nouwen's evocative turn of phrase. A wounded storyteller is a vulnerable healer makes sense of and cares for another based on the nature of her own wounds and stories of recovery. Her wounds become the means by which she understands how to heal others.[57] I decided to engage in this way as a show of trust and as a means to elicit the caregiving side of the chaplains who spoke with me, to draw out their particular gifts based on their particular personal experiences and attributes. I spoke directly and briefly about my own losses so that I could hear more from my respondents

---

[55] Halifax, *Standing at the Edge*, 30.

[56] Ruth Behar, *The Vulnerable Observer: Anthropology That Breaks Your Heart* (Boston: Beacon Press, 1996).

[57] Arthur Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995) and Henri Nouwen, *The Wounded Healer: Ministry in Contemporary Societ*y (New York: Doubleday Image, 1972).

about their own care in responding to loss, grief, and heartache.[58] Once I began to reveal my vulnerability, I could see how bearing witness allowed my interviewees to shift between their social roles (chaplain as agent of spiritual caregiving) and their personhood (chaplain as fellow sufferer) in giving care. For their personhood transformed the endless reservoir of the self for connection and comfort that communicated empathy and compassion, which went beyond any delimited institutional role.

The story of how Farmer, Bangler, Atkins, and Willingham entered into their version of chaplaincy practice speaks to the importance of attending to personal experience in mindful spiritual care. In any version of spiritual care, this gaining awareness of one's self takes engaging in self-examination. The distinctive feature of mindful spiritual care is letting go of preconceived notions of what one will find in order to experience one's self process from the bottom up. One can see this clearly in each narrative. Farmer left her role working in an academic setting for fifteen years to train as a chaplain, deciding through the discernment of her training that a penal and not a clinical setting was the place for her to serve. Bangler decided to leave a job with an academic publishing house and cook in a retreat center kitchen for three years before earning a college degree and concurrently training at UZC to become a clinical chaplain. Atkins pivoted after losing her banking job, following a nascent urge to become a clinical chaplain. Willingham drastically reoriented herself personally and professionally and began working as a chaplain after losing and grieving a son and surviving a divorce. All four stories feature the intersection of mindfulness practices and time: that is, time in a contemplative modality provided the right conditions for the "extended self" of each woman to emerge and strongly urge her to move in the direction of her particular form of service.

All this is to say, the differences between one's social roles—one's story as informant—and one's personal self—one's story as respondent—contribute to constituting a self that is socialized at the same time it is unique. Durkheim speaks to this complex intersection between socialization and uniqueness in his lectures on moral education. All motivated action, he says, develops in the context of the social milieu. Motivated action reflects an interior response to the exterior world.

> Nothing from outside ourselves can tell us which motives should be restrained or contained, or how much energy should be devoted to each of them, or how their influence should be combined, etc. It is ours to feel, and we cannot feel except by coming into contact with the milieu, that is to say, with the things at which our action aims, and by trying things out.[59]

---

[58] As any astute reader will realize, I keep my own losses in the background here as well. I tell their story only incompletely in interstitial moments like this one.

[59] Durkheim, *Moral Education*, 178.

Though social relationships enable human beings to awaken their "extended self" and the "extended self" is enacted through relationships in a community of care, the motivations that orient this self can only be known in the depths of human subjectivity. The interior feeling of rightness in relation to external goals and actions requires experiment, discernment, and in some instances failure. Projects of self-building are radically empirical enterprises, nuanced with proclivity and fraught with the ambiguities of a felt sense of rightness in the embodied self.

Facing loss prepares the way for spiritual maturity, kindness, wisdom, and compassion in caring for others, which mindfulness practices or *zazen* in a community of practice nourishes. I come to this conclusion shaped by my liberal Protestant upbringing, my study of Zen in philosophical and practical dimensions, and my training as a clinical chaplain. While the exact relationship of the neurobiological systems involved and the changes they undergo or the ways in which religious practices of varied provenance cultivate compassion may be in question, the balance of empirical research is tipped toward the assertion that mindfulness can and does stabilize and integrate the self after experiences of loss. It is certainly not the only tool one might use in reintegrating the self after one has undergone a painful loss. Nor is mindfulness a panacea or appropriate to apply in all circumstances. Recent analysis of mindfulness practices does point to limitations of such practices when they are taught without modifications to populations with preexisting psychological disorders. In these instances, unmodified mindfulness instruction can indeed prove harmful. This is notably the case in the event that meditators belong to a minority group that has experienced systematic violence, have post-traumatic-stress disorder, and/or have a personal history of trauma or complex trauma.[60]

In UZC's chaplaincy program, ethical work that orients the self on a pathway of service recruits the sensitive organism of the attuned human body. The spiritually mature men and women who comprise UZC's network of chaplains utilize their embodied awareness as one of the primary tools by which to judge the fittingness of their actions for their external milieu. Community co-regulation and their unique insights into themselves have endowed them with the power to contribute to prosocial projects such as mindful spiritual care and the constitution of compassionate collaborative care. While disciplining the interior body, I would maintain that mindfulness practices concurrently produce notable social effects, which sociological study can analyze as social facts.

---

[60] David Treleaven, *Trauma-Sensitive Mindfulness: Practices for Safe and Transformative Healing* (New York: W. W. Norton and Co., 2018); Jared Lindhal et al., "The Varieties of Contemplative Experience: A Mixed-Methods Study of Meditation-Related Challenges in Western Buddhists," *Plos One* 12 no. 5 (2017): 1-38. Treleaven specifically mentions flooding and traumatic re-experiencing as particular problems that require better training for meditation teachers. Lindhal and colleagues mention several maladaptive outcomes of contemplative practices. In either case, strong warnings about the limits of meditation to generate healing emerge from a careful study of the experiences of persons with a history of trauma of any kind who attempt meditation.

Chapter Five

From Interior to Exterior Spiritual Care

> Mindfulness interventions are important for their potential to reduce stress and burnout and increase empathy and self-compassion. Coming to terms with one's shortcomings is a prerequisite for compassionate care, as a caregiver who is unable to be compassionate toward self may encounter difficulties when confronted with perceived shortcomings of his or her patients.
>
> —Kelly Raab, "Mindfulness, Self-Compassion, Empathy"

After engaging in a year of intensive inner work to reconstitute the relationship between the social self and the extended self in dialogue with other chaplains and retreat participants at UZC, Zen chaplains begin to integrate their skills in deep listening back into the clinical scene. They use resources of self-attunement and self-compassion to engage in the moral practices of spiritual care, interfaith dialogue, grief work, and refining the motivations for their altruism. These moral practices entail feeling, showing, and articulating altered modes of paying attention to the body, paying attention to others through the body, and paying attention to the field of perception beginning with the body but extending outward into the world. In dialogue with their residency cohorts and chaplaincy colleagues, the Zen chaplains trained at UZC direct their mindful attention to the work of clarifying and justifying how their pastoral identity contributes to their acts of spiritual caregiving. Spiritual practices and moral practices interweave, taking into account the various ways that Zen chaplains have experienced and overcome losses, using these remembrances of harms suffered as the basic metal of spiritual presence that Zen chaplains transmute into empathic, attuned, and compassionate care. As the previous chapter examined in depth, UZC leaders call this ongoing process of transmuting grief into the practice of compassionate care "spiritual maturation."

In this work of spiritual maturation, the deeply resonant perceptual field of the body serves as the generative medium of attuned engagements with the persons the Zen chaplain encounters in the clinical world. In this chapter, I will explore how the corporeal schema of a Zen chaplain translates into repeated compassionate actions as a moral practice of responsible spiritual caregiving. I begin with discussion of Joan Halifax's GRACE Model, because of its influence in the spiritual caregiving of Zen chaplains trained at UZC. It proposes a model of grounding compassionate responses in bodily processes. Halifax's Grace Model defines the pathway to a fully realized self (maybe even a dominant identity) as a grounded and mature spiritual caregiver through the incorporation of mindfulness practices into the moral practices of responsible care. After ana-

lyzing Halifax's model in depth, I then relate the experiences of Zen chaplains who improvise spiritual care based on it in the context of biomedical institutions.

The GRACE Model and Compassionate Care

The maturation of chaplains does not occur willy-nilly; it is stewarded by a community of mindful teachers. To this end, Halifax developed her GRACE model to guide students to connect with their own innate tendency to act compassionately when properly grounded in their bodily experience.[1] GRACE is an acronym that stands for five steps in an action sequence designed to promote an appropriate response to the suffering that clinical chaplains encounter in the medical setting. GRACE comprises the following five steps: 1) Gather, 2) Recall, 3) Attune, 4) Consider, and 5) Engage.[2] One practices GRACE in order to establish the neural networks and bodily dispositions for maximal compassion and resilience in distressing conditions. GRACE scaffolds the cultivation of compassion as motivation, feeling, and ultimate value. Here I will elaborate in greater detail how this model promotes compassion and assumes compassion will be the consequence of disarming untimely stimulation of the fear-based responses of the midbrain emotion centers, most especially the amygdala. Through an innovative extension of the Three Tenets, GRACE reinvents the traditions of the ZPO, medicalizing a set of steps that centers on attuned spiritual care, that chaplains can use to stabilize themselves and a clinical environment. Attuned spiritual caregivers bear witness to the suffering they see after they have let go of thinking, feeling, and narrating and recall their true nature as an 'extended self.'

As Farmer explains, Halifax "would put it that compassion arises out of non-compassion elements," including "remembrance" (recall) and empathy.[3] For Halifax, to work skillfully with empathy means recognizing that "we are interconnected with each other and we are also distinct from each other."[4] As parts of complex self-organizing systems called communities, individual human beings are both differentiated and interlinked. One neurobiological view asserts that when the chaplain calms herself by bringing her awareness to her interoceptive neural circuits, she cues the area of her prefrontal cortex for imagining the affective and cognitive world of the oth-

---

[1] For more on the practice of and intentions behind the innovation of GRACE, see John Halifax, "Compassion as the Radicalism of our Time," accessed February 28, 2018, http://www.wisdom2summit.com/Videos/myriad_single_element/1798; and Joan Halifax, *Standing at the Edge: Finding Freedom Where Fear and Courage Meet* (New York: Flitiron Books, 2018), 241-3.

[2] Halifax, *Standing at the Edge*, 241-3.

[3] Rupert Gethin, 2011. "On Some Definitions of Mindfulness," *Contemporary Buddhism* 12 no. 1 (2011): 264. In Gethin's view, this power to recall one's true nature is one of the original meanings of *sati.*

[4] Halifax, *Standing at the Edge*, 83.

ers.[5] Her empathic mirroring might lead to distressing resonances, as the clinical caregiver discovers the sorrow or stress in another that awakens her own mirrored feelings, but these person-to-person crossings provide the base experiential material that she can convert into acts of compassion. "So what can we do as caregivers, as chaplains, as people who are working in these systems to create the conditions for compassion to arise?" Farmer asks. "Understanding compassion not as something that you feel, it's not just a feeling that happens spontaneously from nowhere" is essential to UZC's training. And yet it does happen naturally in the right conditions. Compassion is "something that springs out of a certain set of elements" and "if they are present then compassion happens naturally." We can distinguish three basic ingredients in the practice of compassionate response. First, the chaplain is receptive to the experience of the other—which requires the chaplain to ground herself in her own visceral response by paying attention to what she finds with openness and curiosity. Second, she feels empathic resonance for the suffering she encounters in herself and others. Third, the chaplain converts her empathy into an articulated desire and feeling of warmth for herself and the other. She wishes herself and the other to be free of suffering which entails that she take motivated actions to counteract or repair the wounding she perceives.

If compassion arises naturally when chaplains personally and collectively regulate the conditions of interpersonal interaction, then why is so much attention necessary in order to forestall pathways that lead to greater harm? Inasmuch as human beings are essentially social and interactive organisms that experience emotion and cognition both collectively and individually through mirroring in any given moment, disabling negative reciprocities in human interaction is a necessity, and this includes moments of spiritual caregiving. Farmer mentions the importance of understanding patterns of transference and countertransference, pointing out that past interpersonal experiences may play a large part in shaping a chaplain's current entangled emotions in caregiving encounters.

> I think it is so important, especially in caregiving, because there is such a tendency, no matter if you are caring for a family member or in a hospital or hospice or wherever, to feel overwhelmed by what you are witnessing, whether it is the suffering of the person in front of you or some of the bigger moral and ethical dilemmas that people face in healthcare contexts. How do we meet that and not just shut down?"

---

[5] Keiran Fox et al., "Review Article: Functional Neuroanatomy of Meditation: A Review and Meta-Analysis of 78 Functional Neuroimaging Investigations," *Neuroscience and Biobehavioral Reviews* 65 (2015): 208-228; David Vago and David Silbersweig, "Self-Awareness, Self-Regulation, and Self-Transcendence (S-ART): A Framework for Understanding the Neurobiological Mechanisms of Mindfulness," *Frontiers In Human Neuroscience* 6 (2012): 1-30.

One of the American Zen ways to answer this question initiates a response that reinvents Mahayana traditions in distinctively medicalizing ways. Late modern Zen masters like Halifax reinvent Zen traditions by engaging in a complex method of remembering the past in light of the present. On the one hand, they interrogate the wisdom of Zen traditions or Mahayana Buddhism more broadly. On the other hand, they place the wisdom they find in their tradition in dialogue with the perspectives of modern scientific discourses.

The GRACE model works to convert the elements of experience into virtuous action on behalf of others. The litmus test of such an approach is its ability to convert one's conflictual encounters with adversaries and enemies into compassion for them. A traditional Mahayana Buddhist exemplar that embodies this kind of response is Shantideva, who wrote *The Way of the Bodhisattva* in Nalanda, India some time around the eighth century of the common era.[6] He writes that the means by which to confront challenging situations is to repeatedly practice thinking, feeling, and acting that aims to embody lovingkindness for oneself and others. To this effect, Shantideva shows how to embody the awakened mind—a mind unencumbered by anger, hatred, or fear. He models how to refuse to participate in destructive reciprocities with other human beings. When confronted by those who would harm him, he utters this blessing:

> Those who will falsely accuse me,
> and others who will do me harm,
> and others still who will degrade me,
> may they all share in Awakening.[7]

Taking Shantideva as an ethical example, when the chaplain declines to return hatred, anger, or fear in kind, she enables herself to serve interests greater than herself in each encounter as she discerns their meaning through her contextual engagement with others. She will live out Shantideva's wish for the bodhisattva to serve as a moral exemplar. The GRACE model establishes neurobiological grounds for enacting peacefulness in response for war, care in response to hatred, and wishing goodness in response to spitefulness. The kind of neurobiological grounding found in the GRACE model gives the Zen chaplain the power of feeling the body's inner freedom even in moments of distress.

Halifax is providing a language and spiritual practice that equips hospital chaplains with the means to translate their somatic modes of attention and their experiences from the ritual space of the zendo into the clinical setting. The GRACE model supplies clinical chaplains the means to serve the needs of the clinical setting by transforming themselves into persons capable of virtu-

---

[6] Śantideva, *The Bodhicaryavatara* trans. Kate Crosby and Andrew Skilton (Oxford: Oxford Classics, 1995).

[7] Ibid., 21.

ous response in any circumstance, more able to seek to understand, communicate relationally, and attend to patient needs even when spurned, angered, or belittled by the patient. This transition from the falsely accused, harmed, and degraded person into the agent of compassion comes about in Shantideva's example as well.

> May I be the light for those in need of light.
> May I be a bed for those in need of rest.
> May I be a servant for those in need of service,
> for all embodied beings.[8]

This model does not ensure that Zen clinical chaplains apply it and achieve compassionate action in all circumstances, for compassionate action is aspirational. Chaplains are imperfectly compassionate actors who commit themselves to embodying the values of reinvented religious traditions, and return to a loving and compassionate frame of mind after they realize they have gone over the edge. As a reinvented tradition, the GRACE model elaborates a practical structure that combines the ancient wisdom of Shantideva with current research in neurobiology. It provides the means by which a chaplain can recover her spiritual grounding in her bodily resources when she feels distress eclipse her ability to respond skillfully to the suffering she encounters.

According to the GRACE model, when a chaplain recognizes that she is in a distressing environment, she first needs to gather her attention, usually through the medium of her body. Second, she needs to recall her intention, tapping into her motivational frameworks and corresponding motivational neural circuitry. Third, she needs to attune to herself in relation to others in her context, developing her intersubjective capacity to sense and perceive the experience of others. Fourth, she asks herself to try to find a solution that will really serve all the sentient beings involved in the encounter. In this step, insight and metacognitive processes allow for the possibility of finding a way to resolve suffering. Fifth, she engages with herself and others in order to complete her work of service to them. Perhaps the most important and most difficult step is the very first one: finding one's embodied ground. Consider a chaplain in a distressing environment. If she is confronted with intense pain, suffering, or other psychological distress, she can easily react without regaining her footing. She is greatly enabled if she can recover her ability to feel the sensations of her bodily extremities, for example if she can feel the sensations of her feet planted firmly on the ground. She can tap her hand or chest with her hand and reestablish the boundaries of her physical body.[9] She can recognize that she is safe and has enough resources to meet the challenges of her caregiving task in the present moment. Often, the first step towards embodying

---

[8] Ibid.

[9] Halifax, *Standing at the Edge*, 242-243.

compassion is grounding in one's bodily presence. It requires the chaplain to recognize the body's innate patterns of oscillation between high- and low-arousal states, and to more dexterously modulate between such states.

The GRACE model reflects the insights of various somatic therapies, such as somatic experiencing and sensorimotor psychotherapy. For instance, trauma therapist Peter Levine outlines several techniques like "tapping" that allow a person experiencing an intrusion of traumatic memory to regain a sense of their internal resources by locating the exterior of their body. One taps on the surface of one's skin with one's hand in order to realize the physical limits of the skin and feel the distinctness of that limit. One knows the experience of the body removed from interior processes of cascading distress and fearfulness. One removes oneself from the onslaught of the midbrain fear and anxiety centers and severs the communicate link in the body between the nervous system and the endocrine system. That is, feeling the direct contact of the body's surface on the floor or chair moves awareness from the distressing emotional responses that take a trauma survivor away from the present moment. Feeling one's surfaces re-establishes one's awareness of the present moment of direct sensory experience. As Levine writes, "Grounding and centering, as you shall see, reconnects you directly with resources naturally available in your own body. It is important to re-establish your relationship to both the ground and to your body's center of gravity, the place where action and feeling originate."[10] Finding one's bodily ground is the essential step in learning how to self-regulate. One needs to turn one's awareness to monitoring one's interior and peripheral processes of feeling in order to know how to modify them.

The GRACE model teaches chaplains to "pendulate," empowering them to regulate and thereby learn to control the bodily sensations and accompanying emotions and cognitions that arise in response to environmental challenges.[11] Pat Ogden and Janina Fisher define pendulation as "contacting a difficult sensation and then finding an opposite one" in order to provide emotional balancing as means to self-regulation.[12] From the perspective of trauma theory, Bessel van der Kolk points out that the therapeutic intent of patients intentionally pendulating is to "gradually expand the window of tolerance" for distressing experiences.[13] The Zen chaplain pendulates in order to discover equanimity even in the midst of emotional chaos. Keying into affect, into the particular sensations that flow through the viscera, teaches the chaplain's mind how to translate

---

[10] Peter Levine, *Healing Trauma: A Pioneering Program for Restoring the Wisdom of Your Body* (Boulder: Sounds True, 2008), chapter 4.

[11] Ibid., track 7, audio CD.

[12] Pat Ogden and Janina Fisher, *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment* (New York: Norton, 2015), 496.

[13] Bessel van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2014), 219-220.

the language of the body with greater skill and subtlety. Particular affective flows constitute the sensations of dread a chaplain feels when she has lost a pivotal resource: the loss of a moment to reflect on a past engagement or the loss of a colleague that she found supportive. Affective flows are often too subtle to name, and the contemplative chaplain simply observes the ineffable flux of bodily processes. Thus, the mature and compassionate chaplain is instructed to find and discovers through experience that all joy and sorrow is impermanent. In UZC's style of contemplative care, mindfulness practices provide the means to fully experience, inventory, and then shape bodily and mental responses to distress.[14] Through mindfulness, Zen chaplains can access and have greater control over the differentiated sensing, perceiving, feeling, thinking, and acting domains of the body and mind in order to interlink and stabilize them. Zen chaplains thereby learn how to mindfully care for their spiritual being, growing into greater spiritual maturity. Their spiritual practices become the basis for refining their moral practices of spiritual caregiving.

Mindfulness practice in community teaches the clinical chaplain how to more skillfully pendulate between different domains of experience and layers of memory. This is one of the reasons why contemplative neuroscience is concurrently hypothesizing how mindfulness develops habits of mind that enable chaplains to attend with greater resilience to patient joys and sufferings. Thus Vago and Silbersweig argue that "mindfulness acts as the master self-regulatory mechanism for de-coupling and efficiently integrating experiential and [narrative] modes of processing with the potential to transform the reified self from maladaptive trajectories into more positive adaptive trajectories."[15] Mindfulness practice provides the means to unhitch the wagon of consciousness from self-preoccupied storytelling in order to attend to the needs of others. It is likely that chaplains who practice mindful spiritual care will have greater capacity to bear witness to whatever truths they find. This is probably so even when those truths, heavy laden with suffering, are so hard to bear.

Pathways to Compassionate Action at UZC

At UZC, spiritual maturity names the process by which a self distills its essence in relationship to community, and in response flavors of compassionate response emerge as essential qualities of the unique personhood of chaplains. Halifax's GRACE model provides a processual paradigm for achieving collaborative compassionate care, while Glassman, Halifax, Maull, and other teachers and models serve as embodied paradigms. In the interior process of reshaping the self

---

[14] Daniel Goleman and Richard Davidson, *Altered Traits: Science Reveals How Meditation Changes Your Mind, Brain, and Body* (New York: Penguin, 2018), 6.

[15] Vago and Silbersweig, "S-ART," 20.

in response to exterior events, the essential nature of the self is not expressed in a once-and-for-all way. The self is expressed continuously through gestures of care directed at others, oneself, and world at large. Compassionate response is the motivated behavior that leaders of various schools of contemporary Buddhism suggest is at the core of all religious traditions. An essential ingredient of humanness, compassion as an emotion, motivation, and action is spiritual in that it is not confined to any religious tradition or its doctrine. It is rather shared by most if not all religious traditions. Interfaith leaders like the Dalai Lama make the point that compassion, kindness, love, and forgiveness are not luxuries but necessary for human survival.[16] In a similar vein, researchers in psychology like Eleanor Rosch agree that Mindfulness Based Stress Reduction (MBSR) and other contemplative training regimes, secularized or still grounded in a religious tradition like Buddhism, cultivate "the kindness and compassion embraced by all of the world's religions and ethical systems."[17] Views about how styles of compassion are manifested in particular religious traditions show some consensus, though views on how one cultivates compassion are various. Similarly, religious leaders engaged in contemplative social activism and scholars who study it empirically largely agree that compassion is an ultimate motivator of prosocial behaviors. Since contemplative practices ground and stabilize the mind, contemplatives believe that their practices enable them to remember the innately good qualities of personhood like equanimity, empathy, altruism, and compassion. What is clear in studying contemplative practices across religious traditions is that variations in contemplative practice cultivate different styles of character trait. For instance, Rosch asserts Christian "centering prayer requires a very different kind of attention than mindfulness, a giving out and opening up, not a close pointillist attention."[18] Centering prayer is a memory practice of a different kind, in which those in prayer come back to the divine presence and action within the body as they pray, finding themselves deeply penetrated by God's grace.[19]

---

[16] Dalai Lama, "Cultivating Altruism," in *The Engaged Buddhist Reader*, ed. Arnold Kotler (Berkeley: Parallax Press, 1996), 4.

[17] Eleanor Rosch, "The Emperor's Clothes: A Look Behind the Western Mindfulness Mystique," in *Handbook of Mindfulness: Culture, Context, and Social Engagement* eds. Ronald Purser, David Forbes and Adam Burke (New York: Springer, 2016), 289.

[18] Ibid. Centering prayer in this case would involve open monitoring (OM), but I would disagree with Rosch that OM is not included in mindfulness practice. Centering prayer does not require work in the domain of focused attention (FA), and this distinguishes centering prayer from mindfulness because it omits the concentration work that is preliminary to open monitoring in mindfulness practice.

[19] Thomas Keating, *Invitation to Love: The Way of Christian Contemplation* (London: Bloomsbury, 2012), 140.

Michael Spezio's research provides a social neuroscience perspective on *anemnesis* (remembrance) as the Christian analog of mindfulness practice.[20] Spezio notes that communities of Christians remember Christ in ritual acts like the Eucharist, which are the ritual bases for the collective life of churches. Christians repeatedly participate in this kind of remembering during Church from the time when training implicit memory systems of the enactive self dominate human formation in early childhood. Anamnesis resembles the remembrance performed in mindfulness in that the person who remembers channels the pattern of an archetype in responding to others in the world. The person who takes communion remembers Christ's self-giving kenosis (Christ's pouring himself out for the world) in preparation to imitate him, just as the person who practices mindfulness sits like the Buddha under the Bodhi tree in order to awaken to his true nature and see the truth of impermanence, suffering, and liberation from suffering. The pattern of self that the follower remembers enacts an identity that enters into a salvation history of a Buddhist or Christian hue, but remembrance is the formative action in either case.

As Spezio makes clear, the point is that remembering as eucharistic mindfulness plays an integral part in providing Christians with a means to imitate Christ; that is one remembers Christ in order to become like him in mind and body, converting *sarx* into *soma*.[21] Christian communities remember the body of Christ in taking and eating the bread of the eucharist in order to make of their own bodies bread for the world.[22] That is, Christians remember Christ's sacrifice so that they can learn to sacrifice themselves for others. Memory in this sense is a spiritual value with cognitive and affective dimensions that reinforce each other; it infuses the imagination and interior moral spaces of the body.[23] The performance of the Eucharist in community enacts the collective imitation of Christ, who compassionately sacrificed himself for the world. It is well beyond the argument of my dissertation to elaborate a comparison on this point at length, but pointing out these similarities is a useful way to show that what is at stake is nuance of approach to common human experiences rather than categorically different experiences. In mindful remembering, one learns how to pay attention *to* the body (its internal sensations and affect) and *with* the body (as a medium through which to view exterior phenomena), constituting knowledge of

---

[20] Michael Spezio, "Forming Identities in Grace: Imitatio and Habitus as Contemporary Categories for the Science of Mindfulness and Virtue," *Ex Auditu* 32 (2016): 128-129.

[21] Keating, *Invitation to Love,* 13. Keating writes of the difference between *sarx* and *soma*, "*sarx* is the body and the psyche locked into survival at its present level of human development. *Soma* is the body open to transcendence."

[22] Henri Nouwen, *The Life of the Beloved* (New York: Crossroads Publishing Company, 1991); Nouwen bases this text in the transformation that the eucharist enacts in Christian communities. The eucharist becomes the means by which the members of the community are made a living sacrifice for the world. Sharing one bread ultimately means becoming the bread of the world.

[23] Spezio, "Forming Identities in Grace," 134.

the body (that is symbolic knowledge made with, by, and for the body about its ways of orientating within the world).[24] A person does not take communion alone, nor is mindfulness a solitary practice at UZC.

Acts of mindful remembrance, inflected in different ways by different religious commitments, like eating the eucharist or sitting in meditation, reshape "somatic modes of attention," culturally elaborated ways of "attending to and with one's body in surroundings that include the presence of others."[25] This means that attending to the body produces a way to attend to the world through the body. The body acts as medium as well as representation, and body as representation is always secondary. In the lived experience of caregiving, the body is felt or sensed rather than merely imagined. Religious traditions share an appreciation for the forceful role of ritual as a means of altering somatic modes of attention and in which religious communities participate in order to embody religious exemplars. The clinical chaplain narratives that follow are about monitoring and modifying consciousness. They show how mindfulness practices extend beyond the formal setting of meditation retreats. In the context of late modern clinical chaplaincy practice, the clinical experiences of chaplains become the material with which spiritual caregivers rework mind-body, inexorably refashioning character by turning positive mental states into permanent, adaptive traits. What distinguishes these chaplains as "late moderns" is that they are not convinced that secularization will transplant religious beliefs and practices, and therefore forms of enchantment are just as viable an option for a rational selves as secularized views divested of sacred presences.

When the Zen chaplains trained at UZC provide compassion through practices of mindful spiritual care, they remember an 'extended self' as the self imagined by late modern American *dharma*. By imagining the self in this way, and embodying a field of perception that does not make insuperable boundaries between self/world, they re-enchant reality and question the premise of modernizing rationality that makes of the world a kingdom of means and the human being a kingdom of ends. As the product of practices of mindfulness mediation, this 'extended self' resembles earlier Zen constructions, but places greater emphasis on providing more nuanced descriptions of the neurobiological basis of awakening. In Zen Buddhist communities, students of Zen remember (that is cognitively know and knowingly embody) *dharma* as a dimension of human experience that transcends a person's unique selfhood. For dharma to have transformative power, it must transition from the world of imagination into the world of practical action that draws attention to how *dharma* feels in the caregiver's flesh and bones. It must be realized in the material of the body. Zen Buddhists remember their basic and natural equanimity in pausing, let-

---

[24] Michael Jackson, "Knowledge of the Body," *Man* 18 no. 2 (1983): 327-345.

[25] Thomas Csordas, "Somatic Modes of Attention," *Cultural Anthropology* 8 no. 2 (1993): 138-140.

ting go, and lovingly attending with awakened awareness to their bodily experience and the expressions of other bodies. American Zen Buddhist remembrance holds that attending to sensations of craving pleasure and avoiding pain with equanimity is foundational to ethical action and ethical action tends toward compassionate responses. These Buddhist teachings on compassion are common to Zen, Tibetan Buddhism, and Theravada. They assume that all human beings will find a compassionate and tender heart underneath all the survival thinking and fear reinforced by forms of social conditioning that focus on competition. In my interviews with students of UZC's chaplaincy program, I explored how they view (imagine) and experience (embody) compassion. According to the chaplains that UZC trains, what does compassion look and feel like?

American Zen communities who trace their lineage through Bernie Glassman hold fast to the Three Tenets that ground the Zen Peacemaker Order (ZPO) at the same time that they reinvent them. The Three Tenets assume that compassionate action will be sensitive to context and assuage the suffering it encounters. Zen Buddhist chaplains taught at UZC assume that compassion arises from disentangling the mind from its conditioned responses that serve to protect the limited self. American Zen Buddhist teachings on the natural state of the mind figure it as a free and open space in which a practitioner of *zazen* can enduringly abide. This notion of the openness and flexibility of the mind undergirds the assumption that compassionate action will arise as the most flexible and skillful response to suffering once a chaplain deconstructs conditioned reactive habits. Examples of this kind abound in stories of seasoned meditators who embody equanimous traits and have an ability to respond from a place of quiet and stillness, choosing actions that will serve a higher purpose. UZC's chaplains narrated many everyday stories of compassion in action. Moreover, clinical chaplains of various faith backgrounds have prized compassion as a necessary value for their caregiving practice, despite nuanced views on the ways in which a chaplain might cultivate, experience, or practice compassion. Though religion-specific expressions of compassionate action show nuance and particularity, the family resemblance between actions interpreted as compassionate is striking. Resemblances among acts categorized as compassionate make translation between these forms not only possible but also likely.

It is the everydayness of interpersonal wounding and clinical chaplaincy's compassionate response that is so striking. These stories argue that harm and compassion are not only for battlefields or exiled political leaders like the Dalai Lama, as the Dalai Lama himself has said. Compassion is not a luxury but a necessity. For instance, Linda Atkins told the story of a patient she met in San Francisco's Zuckerberg General Hospital who related to her the events of his childhood that brought him great distress even after many years. When he was a young boy, his parents divorced and they shared custody of the children since neither parent could take on the responsibility of caring for the children alone. He had proven intractable to discipline. Atkins said he had been labeled an "uncontrollable child," so his parents decided to give him up for foster

care at the age of five. He was sent to live in a foster home for many years. After around seven years elapsed, his father turned up and promised him, "I am going to take you to live with me! And I am going to get you a dog! And I'm going to be back on Monday, and you are going to come live with me!" The excitement in Atkin's voice mimicked the boy's state of expectation and hope to live with his father again. It foreshadowed the defeat that would come.

As Atkin's continued the tale of the family's split, I could anticipate the tragic ending. Overcome with rapt excitement, the boy prepared himself for his father to come and take him back. "Monday he went out to the front of the foster home where he was living with his suitcase," Atkins narrated, "and his father didn't turn up. He [the boy] said he refused to leave that porch for three weeks, night and day," Atkins said. Her voice took on an almost hushed tone. The empathic pain lived in the quiet of her voice and communicated her lingering resonance with the man, which remained lodged in her since he described his anguished boyhood. Anticipating his father's arrival, the boy stayed on that porch, "until he realized that his father was never going to come." The boy grew to manhood and later came to know his father better, but never once did he receive any explanation as to why his father had promised to take him away from the foster care home and failed to fulfill what he promised. Sorrow for the boy resonated in Atkins and other the nurses who tended to this man. They felt the hurt of a boy who wanted so much to rejoin his father that he camped out on the porch of a foster home for weeks even though his father would never come to retrieve him. The man wept as he told his story to members of the clinical team treating him. He said to them that he had not wept in years, but each time he talked about his childhood and its many hardships the tears would fall. The medical staff were touched by his tears, and some of the nurses wept alongside him, bearing witness to the wounding he survived and imagining the small boy who suffered from so much pain.

Compassion is not empathic resonance alone. It also means taking action to alleviate suffering that goes beyond feeling another's pain, sorrow, or grief. Atkins described her response to the man's story by saying though she cried she maintained her peacefulness toward herself, the other clinicians, and the man. She said she chose to be physically and emotionally present in a "posture of tranquility," crying in a way that maintained her strong connection with the man. She elaborated:

> So part of it is choosing to physically be there, to physically be settled, and to assume that posture of tranquility, and to let myself feel as well. There was a moment in that conversation when I got out my handkerchief and dabbed at my eyes because a tear came to [emphasis] my eye. It was probably when he was telling that exact story. Just to think of that child waiting, waiting, and waiting and his heart breaking.

It seemed to me that she was reliving this experience of agonizing pain in telling me the story, though she maintained her 'posture of tranquility' as she talked. Compassionate care provided

the interpersonal warmth that melted the man's heart enough so that his tears could flow after so many years staying silent in seething resentment. The collective product of a team of compassionate caregivers who focused their attention on the patient's pain constructed a healing context. By listening to what this man's wounded heart needed to say after so many years of silence, they created an interpersonal context of care. "Anyway, it is possible to let my emotions be present," Atkins concluded.

Neuroscience researchers Tania Singer and Olga Klimecki stress that the wish to end the suffering of the other, even if this is entirely impossible, is the necessary added ingredient that differentiates compassionate response from empathy.[26] To cry with another, even with self-composure, is a compassionate action on behalf of the other in that it displays solidarity and feeling for his pain but also care. In what Shane Sinclair and his colleagues name the "relational space" of a clinical caregiving encounter, patients claim that they can "feel people's compassion" and understand it "just by their body language."[27] Patients perceive the "virtuous response" of caregivers as the "enactment of virtue toward a person in suffering" when caregivers seek to understand, communicate in a relational way, and attend to patient needs.[28] One of the most famous exemplary types to embody this form of compassionate response is Jung's wounded healer, a trope played on in the writings of Henri Nouwen and Arthur Frank.[29] A healer's wounds provide the pathway for compassionate healing, since knowing her own wounds endows a healer with empathy and motivation to end the pain and suffering of another. Wounded healers know their own vulnerability, and so know how to tend to vulnerability in others.

Halifax relates that the "archetype of the wounded healer" embodies "the experience of altruism rooted in the expression of suffering that has been transformed into boundless compassion."[30] The adaptation of the trope shows the breadth of religious liberalism's cross-tradition borrowing, since Halifax's sources work in spiritual and intellectual traditions little influenced by Buddhism. These projects aim to reorient clinical contexts so that clinicians working in them pay greater attention to patient experiences of illness. In Nouwen's formulation, a wounded

---

[26] Tania Singer and Olga Klimecki, "Empathy and Compassion," *Current Biology* 24 no. 18 (2014): R875-R878.

[27] Shane Sinclair et al., "Compassion In Health Care: An Empirical Model," *Journal of Pain and Symptom Management* 51 no. 2 (2016b): 196.

[28] Ibid., 197. This model of compassionate care has empirical evidence that captures patient views on compassion to support its claims to validity. The authors used grounded theory to analyze semi-structured interviews of 53 advanced cancer inpatients to generate their qualitative data.

[29] See Henri Nouwen, *The Wounded Healer: Ministry in Contemporary Society* (New York: Doubleday Image, 1972); and Arthur Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995).

[30] Halifax, *Standing at the Edge*, 49.

healer provides the space in which a patient or parishioner can achieve greater wholeness because the wounded healer has the steadfastness to bear witness to pain and suffering. They harness the awesome transformative power of bodily experience to enable the spiritual growth of others. A wounded healer leverages both the light and shadows of her own desires and bodily capacities in her intimate relationship with others. She brings the light and dark aspects of her experience to bear on her relationship with others who suffer, serving others in the humility of tender and attuned care. She knows the pain of the wound, knowing her own wounds. She acts skillfully on that knowledge. Oriented by her intuition she serves as that intuition arises from bearing witness.

In the task of bearing witness, awareness is the central tool a Zen chaplain uses to monitor and modify behaviors, thoughts, and feelings in her consciousness and body. In times when the mind is hijacked by afflictive emotions, this may require locating the limits of the physical body, her internal sensational and emotional responses to stress, and the cognitive accompaniment to emotional and sensational response. Self-regulation requires learning to befriend her bodily responses, emotional experiences, and cognitive process, processes which require the chaplain to enter into a collaborative relationship with herself and others. This means finding a way around reactive responses to others in the event the chaplain faces an internal conflict that a patient triggers. Consider the story of Matt Nettles's visit to a man hospitalized after suffering a stroke. Nettles is a white Protestant who has been practicing mindfulness meditation for a decade and has participated in intensive retreats at UZC. Nettles said that the patient he visited looked imploringly out at him as he was making his rounds on the third-floor ward of the hospital where he works. "I felt that he wanted to talk to someone, so I decided to introduce myself to him." Nettles greeted the patient, shook his hand, and asked if he could sit down. The patient motioned for him to sit and then began to narrate what happened to him. He spoke rapidly, waiting only for the briefest moment to make sure that Nettles was tracking him. The man told of how he had worked in manufacturing for many years, worked hard for much of his life, lauded the current trend toward conservative government, and decried the recent trend of gun violence in schools. "My father would have beat my ass if I acted the way teenagers do today," the man opined. "They all need a good ass-kicking."

In the course of the conversation, Nettles, an avowed religious and political progressive, noted his own replies became more staccato and curt, his tone of voice shifted, and his body reclined back in his seat. He felt his gut get tight. His body language projected a feeling of avoidance and his insides signaled fear. After suffering the loss of an important interpersonal relationship, Nettles had begun to practice a form of meditation that focuses on showering others with lovingkindness. One imagines taking the pain of the other and giving peace and tranquility in return. One begins by imagining this exchange with one's self, one's mother, a friend, someone

neutral or unknown, and one's foe. All the while one is taking in the painful energy of the other—imagined as black smoke—as one gives back to them pure and blissful love—imagined as white light.[31]

> As I realized that I was walling myself off to this man, I leaned forward and tried to soften. I imagined him as an enemy or someone who had hurt me, and I felt myself taking in his darkness and despair over finding himself in this hospital in a country that he no longer recognizes as his own because it is so different from the one in which he grew up.

After he shifted his internal posture from resistance to receptivity, Nettles noticed a change in the man's voice. The man seemed to calm and settle into himself more. A few minutes later a nurse came in as the conversation reached a lull, and Nettles went to leave the room. The man reached out to shake Nettles's hand, and both men exchanged a warm farewell.

Nettles admits he cannot confirm what the man felt or if his attitude had in fact shifted. Nonetheless, at the very least, Nettles can say confidently that his ability to respond internally to his own arising avoidance provided him with the means by which to "down-regulate" rising anger by sensing its bodily markers before it exploded into reactivity.[32] The ability to modify one's anger through mental activities that are believed to correlate with the prefrontal cortex is possible because the dorsal prefrontal region of the brain is a "zone of convergence."[33] In learning to monitor and modify inner experience, the mind avails itself of prefrontal brain structures to objectify, redirect, and integrate mental and bodily experience. Early explicit awareness of bodily markers of amygdalae and midbrain activation can give the experienced meditator greater conscious control of prefrontal zone capabilities to dampen aggression. Once a mindful spiritual caregiver has realized that a space exists between an experience of anger and her own identity, she can choose a different pathway of social and emotional processing. Greater mindfulness of bodily processes and sensations through grounding practices then affords a chaplain the ability to read interior experience and anticipate conditioned reactivities to environmental stressors. Mindful spiritual care means being able to maintain a view on inner and outer experiences that is open to various options for acting. In this mode of the practice of spiritual care, a chaplain can gather

---

[31] A fairly accessible description of the very similar practice of *metta*—lovingkindness meditation—can be found throughout Sharon Salzeberg's *Lovingkindness: the Revolutionary Art of Happiness* (Boston: Shambala,1997). The practice Nettles describes is *tonglen*, a Tibetan visualization meditation that activates compassion neural circuits in a similar way. See Pema Chödrön, *The Places that Scare You: A Guide to Fearlessness in Difficult Times* (Boulder: Shambala, 2017), Chapter 9, Audible.

[32] Antoine Lutz et al., "Investigating the Phenomenological Matrix of Mindfulness-Related Practices from a Neurocognitive Perspective," *American Psychologist* 70 no. 7 (2015), 649.

[33] See Naomi Quinn, "The Self," *Anthropological Theory* 6 no. 3 (2006), 371; and Joseph LeDoux, *Synaptic Self: How Our Brains Become Who We Are* (New York: Viking, 2002), 180.

and survey the fullness of bodily experience while muting self-evaluations before she remembers her intentions in acting and attunes to what the patient might need.

All this is to say that mindful spiritual care trains the chaplain to repeatedly engage in self-examination, but this self-examination is relentlessly non-evaluative. When thoughts, feelings, and perceptions bound up with judgements arise, the mindful spiritual caregiver lets them persist in consciousness and fall away again without resisting them. When these self-evaluations fall away, she merely returns to anchoring her attention in the breath or the fluid perceptions of her conscious engagement with the world around her. When the mindful clinical chaplain down-regulates anger she begins with sensing as fully as possible its bodily presence—the bodily sensations associated with anger in the distinct locations where these sensations arise. She feels tightness in her abdomen and constriction in her throat. If she believes the afflictive emotion might cause harm to herself or another, she might engage in an antidote practice like *metta* or *tonglen* like Nettles did. In that case, she may choose to activate brain circuits and mind states that are mutually exclusive with anger, fear, or hatred. One can see this process at work in Nettles's story. After noticing the sensations correlated with anger arising in his body, Nettles consciously shifted into a compassionate response to the pain and suffering of the man he encountered in the hospital room, even when the man had triggered an emotional and motivational avoidance response in him. Nettles would be the first to admit that he still often reacts without consciously making choices, but he says that he feels a growing sense of freedom in choosing how to engage with the suffering he finds in the social contexts in which he lives and works.

While Nettles curbed his own anger and redirected himself toward a more compassionate response, other examples abound of mindful chaplains embodying tender responses to distress other clinicians might not quickly notice. They tend to enter into this work through their grounded and receptive presence. Michelle Nicole, a chaplain who completed her training at UZC in March of 2017, tells just such a story. She began her professional career as a neuroscience researcher and later decided to become a spiritual caregiver in order to contribute more directly to the wellbeing of people in distress. Her decision came out because of a personal vow to provide the kind of support her elderly mother did not receive in the wake of Hurricane Katrina, as much of New Orleans, where her mother was staying in a nursing home, was destroyed by the flooding after the storm. In response to my question about using contemplative practices in her work, Nicole told me about her chance encounter with a woman whose husband had just had a heart attack: "One time I stumbled across a woman in the hallway whose husband had just suffered from a cardiac event. She was squatting down and her back was against the wall. She was certainly in a tizzy, and she was feeling sick." Nicole noticed her as she walked the halls, but she was the only clinician to respond. First, and perhaps most importantly, Nicole had the capacity to remove herself from the force of routines that can come to dominate the perspectives of clinical

caregivers.[34] This, perhaps, is the province of any spiritual caregiver, but what makes Nicole's intervention unique is how she directs the woman's attention to her bodily ground at its margins, that is away from the distressed interior of her body to the safer periphery. When flooded with panic, it is the outer edge of the organism which holds the key to detente. She continued, "She wasn't quite hysterical with worries but she was very close. She also had a friend in the emergency room. I went with her into the waiting room and we sat down. After she sat, I directed her to bring her attention to her feet on the floor." The woman was a fervent evangelical Christian, who "was praying out loud to the Lord" in the style of charismatic Protestantism as Nicole guided the woman's attention to the limits of her body. The woman calmed.

Next Nicole invited the woman to bring "her attention to her feet and her back on the chair. She was sitting with those experiences, and then she was able to think more clearly and make plans about how to get her diabetes medicine" The story points at a phenomena that attachment literature shows through empirical study, when one human being uses emotional resonance to attune to the experience of another, this provides an empathic bond that allows the resonating caregiver to subtly influence the person experiencing emotional distress. After she regained her composure, the woman thanked Nicole. "She was very grateful for everything I helped her with. She was in a panic before, and we found a grounded place together with enough space to make decisions." Nicole did not entirely explain why this particular woman responded so receptively to her guiding presence. She pointed to the fortunate circumstances of making a connection, saying, "it seems lucky" that the woman responded so favorably to her presence. A mysterious quality is present in the story, for how could Nicole predict the woman would trust her and follow her lead? What Nicole could control was the use of her self-attuned and regulated nervous system to extend balance into the woman's internal milieu, sharing energy across their bodily boundaries. Nicole's acquired trait of equanimity amidst interpersonal distress facilitated the compassionate connection between both women.

This story exemplifies the power of Halifax's model to structure the moral practices of spiritual caregiving. While at no point in her telling of this story did Nicole refer explicitly to the GRACE model, her narrative of the events clearly shows it guiding her behavior implicitly. The interaction between Nicole and the woman shows how empathic resonance and emotional mirroring require a degree of emotional balance. Since the practice of mindfulness permits a greater ability to down-regulate fear responses of the amygdalae and midbrain structures through "fear modulation," the first step of GRACE or the Three Tenets is letting go of the defensive delibera-

---

[34] Sharon Kaufman, *—and a Time to Die: How American Hospitals Shape the End of Life* (New York: Scribner, 2005); Helen Stanton Chapple, *No Place for Dying: Hospitals and the Ideology of Rescue* (Walnut Creek: Left Coast Press, 2010).

tions of the fearful mind.[35] The Zen chaplain regains balance by finding some locus of calm in the mind's relationship to the body. Grounding counteracts what Joseph Ledoux expresses so neatly about fear's impact on cognition: "the net result is that emotional arousal penetrates the brain widely, and perpetuates itself."[36] A fearful midbrain perpetuates its emotional state and fearful thinking, thereby priming the senses to perceive the presence of threat in neutral stimuli. The principle brain regions responsible for this narrowing of perception—namely the amygdala—trigger a cascade of chemical and neurological mechanisms that activate arousal states in multiple biological regulatory systems. Arousal states are self-perpetuated by emotional and cognitive looping, whereas bodily sensations without cognitive reinforcement tend to fluidly rise and fall away. If the chaplain or patient can train awareness on feelings at the extremity of the body, less influenced by affective and cognitive looping, she can often regain self-possession.

Neurobiological research suggests that fear responses can be modulated through inhibition. Mindfulness practices can train the prefrontal cortex to down-regulate amygdalae activation through the deployment of inhibitory neurotransmitters.[37] The chaplaincy instruction designed by UZC's leadership applies this knowledge to the cultivation of equanimity in clinical chaplains. Because Nicole maintained emotional balance through equanimity, she could provide the woman she encountered with the attuned care that the woman needed to regain her own balance. At the same time, her previous career and UZC's neuroscience of compassion training provided Nicole with the conceptual scaffolding to imagine and tell a clear narrative about her interaction with the woman to me. In the heat of the moment, Nicole herself was able to consider how best to respond to the woman's distress and then was able to display the bodily posture, voice, and breath associated with calm. After her bodily display presented calm, she gave the distressed woman clear guidance about how to recover a self-regulated state. Once the woman calmed herself, both women discussed options together for how to relieve the woman's acute bodily distress. The woman had forgotten her diabetes medicine, but came up with a sound plan to get access to it again quickly. In the last step, Nicole pursued the engagement to its natural resolution, saying farewell to the woman after she seemed steadied and equipped to confront the challenges her life presented to her.

The story demonstrates the value of the GRACE model by pointing at the fruits of mindfulness in spiritual care that come about when mind-body states solidify into more permanent char-

---

[35] Daniel Siegel, *Mindsight: The New Science of Personal Transformation* (New York: Bantam Books, 2010), Chapter 1, Audible. Siegel describes nine functions of the mPFC, including "fear modulation."

[36] Joseph LeDoux, *Synaptic Self: How Our Brains Become Who We Are* (New York: Viking, 2002), 320; Siegel, *Mindsight*, Chapter 1.

[37] LeDoux, *Synaptic Self*, 53-61: notably the nervous system is responsible for activating the hormonal controls of the endocrine system through the hypothalamus-pituitary-adrenal (HPA) axis.

acter traits, that is once mindfulness becomes implicit. What was once a more temporary outcome of practice—equanimity—becomes a dominant response that is integrated into implicit memory. One valid manner in which to develop the virtues associated with compassionate collaborative care in the clinical setting is through mindfulness practices and/or *zazen* in a Zen community. No empirical research exists at the moment to assess how patients receive or evaluate mindful spiritual care, but studies do suggest that compassionate responses benefit caregivers and prevent caregiver burnout.[38] If compassion is a natural feature of human being, anyone can find it in themselves. Training merely increases a caregiver's likelihood of finding this innate resource and adapting it to her prosocial aims in constituting a community of care. In this work of constituting a community of care, the similarities between the Three Tenets and the GRACE model are quite clear. Halifax's work has been to elaborate with greater neurobiological clarity and nuance how the not-knowing mind positions awareness in a stance of receptivity to experience. Her work draws more attention to the body than Glassman's as the necessary ground in which to gather one's awareness. Her elaboration is informed by the wealth of research flooding academic neuroscience journals and conferences on contemplative care in the last three decades. Halifax's body of work suggests that when chaplains abide in the not-knowing mind, just as when they gather the sensations, emotions, and cognitions of their inner state, they are receptive to and can work dexterously with the experiences they find.

Clinical chaplains who embody compassion inhabit interior and exterior places of acute discomfort. To attend to the suffering of others and wish that they would emerge from their trial with greater freedom means suffering alongside them. Retired palliative care chaplain Rick Freeman exemplifies how to suffer alongside others in his story about visiting a young father who was actively dying. The man's wife and adolescent daughter were understandably struggling to let him go. Freeman completed UZC's chaplaincy training toward the end of his career working in clinical settings at a community hospital in Oregon. Freeman observed the man endure agonizing pain battling leukemia for several weeks. Blood often flowed from every orifice of his body. "One day, I got to speak with him before she [the man's wife] came in," Freeman said, "we were just talking and I asked him, 'How are you doing? How is your experience going?' It was a fairly simple conversation, and he said to me, 'Rick, I think I am done. I don't think I can do this anymore.'" Wanting to have a better picture of what the man felt about what his death might be like, Freeman asked the man how he envisioned his death. The man said, "'Well, my brother's coming.' I always get emotional when I get to this point of the conversation when I tell this story." I could hear Freeman's voice break with sorrow. "'My brother is coming. He will be here

---

[38] Shane Sinclair et al., "Compassion: A Scoping Review of the Healthcare Literature," *BMC Palliative Care* 15 (2016a): 10. This meta-analysis cites four studies that support the claim that compassionate care increases job satisfaction and retention.

this afternoon. I want to make sure that I get to see him.'" Freeman then asked the man if he could help with anything else, and the man said that he wanted Freeman to stand in support of him as he told his wife about his decision to forsake all means to prolong his life.

Attentive to the distress of the clinicians, Freeman served as the communicative bridge between the patient, his family, and staff. After the man told him of his wishes, Freeman wanted to speak with other clinical staff to see if they needed his support. He felt certain that the nurses were eager to begin the process of transferring the man to a local hospice. Freeman was solicitous, repeatedly asking the man at each step, "Is that alright with you?" Once the man made his decision, Freeman nodded at the nurse and she anticipated the news he bore. "She reached out for the phone immediately . . . because she wanted his suffering to end. It was her challenge too." As so often happens with chaplains, they serve as the circulators of important messages and meanings related to death and dying. Even though the chaplains that Wendy Cadge interviewed in her fieldwork in the early 2000s were "defining spirituality as more than religion" as "a strategic approach" that expanded "their professional jurisdiction" to provide care to patients and families who are not religious per se, there has been remarkable continuity in associating chaplains with end-of-life care in her work, my interviews, and my clinical training.[39] Hospital staff continue to closely link chaplains of various faith backgrounds with death, and spiritual caregivers still tend to play an essential role in the biomedical construction of dying.[40] For example, Freeman's institutional role and pastoral training equipped him with the steadfastness to open himself to the truth of the dying man's situation and relay the information he received to other clinical staff. He knew the nurses were waiting anxiously for the husband and wife to decide to transition him away from curative measures. Soon after Freeman and the dying man resolved to meet with his wife, she came in and greeted the two. Her husband looked at her tenderly, said hello, and asked her if Freeman could stay with them and be present as they talked. His wife agreed, then the man told her that he wanted to die. Up until that moment, they had maintained the appearance of the good fight. In the aftermath of his confession that he wanted to move to hospice, his wife wept with him. "She cried, but she accepted it. She knew it was coming." Husband and wife were able to openly share their grief together.

In his relationships with staff and family, Freeman elicited and then announced the intentions of the patient. He provided the welcoming sacred moral space for the painful decision that the man must make. That is, Freeman and the couple in relationship and through dialogue created the

---

[39] Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012), 199.

[40] See Cadge, *Paging God*, 171-190, for a comprehensive description of the ways in which chaplains "manage death," doing what Cadge names organizational "dirty work."

"sacred space" in which "it can be openly acknowledged that holy things are happening."[41] His many decades of practicing mindfulness allowed him to abide in an open and aware state while with the patient and his wife. Freeman describes his self-monitoring as watching himself and the patient interact from a distance. Regular mindfulness practice gave Freeman the power to notice the pain, fear, and heartache in the dying man, his family, and clinical staff without feeling overwhelmed by them. They resonated in him, but he felt himself free to choose how to respond. In his actions and internal process, Freeman advocated for what was best for the patient and then stepped back so that the man could carry out his wishes. He provided the supportive presence that strengthened the man to carry out the arduous task of accepting the experiential truth of his process of dying. Compassionate response is comprised of and integrates motivation, sensation, and action. It grows from a felt sense of the mind entrained to the heart attuned to another human who suffers. The suffering of this other urges action.

Chaplains can represent the flesh and bones of caregiving in narratives about their clinical caregiving practice, but the heart of mindful spiritual care lives in the body. Atkins's compassionate ears and heart, Nettles's deft emotional rudder, Nicole's breathing body and tenderly reorienting voice, and Freeman's spacious inner witness all show how the fruit of practice becomes the embodied path, and the path becomes the embodied trait. The most essential move in this practice of mindful spiritual care is the simple act of letting go of the assemblages of inner experience to return to bearing witness to what one perceives in any given moment. The mindful spiritual caregiver pauses, and lets go of the aggregates of human experience to allow herself to bear witness to the complex web of interrelating identities, relationships, and values at play in the perceptual field. This perceptual field comprises both interior and exterior domains, exteroceptive and interoceptive processes, and the body serves as the object of awareness and the medium through which to become aware of others. Mindfulness enhances a clinical caregiver's volitional control over where she places her attention, and other forms of attention training could serve similar purposes in clinical settings. Yet these stories say something else about mindfulness practices, which only more research about alternative contemplative practices will show is generalizable with reference to various contemplative traditions. These stories exemplify psychologist Daniel Goleman's and neuroscientist Richard Davidson's assertions, based on nearly two decades of solid empirical neuroscience data, about how mindfulness meditation alters traits of mind bringing about greater stability. They claim this body of research shows that mindfulness meditation cultivates: 1) resiliency to stress, 2) enhanced empathy and compassion, 3) attentional

---

[41] Margaret Mohrman, "Ethical Grounding for a Profession of Hospital Chaplaincy," *The Hastings Center Report* 38 no. 6 (2006): 22.

control, and 4) and an expanded sense of self.[42] Their analysis of meditation research posits that mindfulness practices engender spiritual maturity, which optimizes a clinical chaplain's ability to handle stressful circumstances, intensifies compassion for self and other, guides awareness, and relaxes a chaplain's sense of boundedness.

The narratives of Atkins, Nettles, Nicole, and Freeman show why these skills and traits are necessary in chaplaincy and describe them *in situ.* Halifax's GRACE model maps a clear way that clinical chaplains can orient their journey to spiritual maturity. Bearing witness over and again to the joys and sufferings of the clinical world, these chaplains are honing the core character traits of mindful spiritual care. As Freeman repeatedly says to describe his work: "I bear witness to the joy and suffering of their lives."[43] Bearing witness to the patient elicits the empathy that skillful chaplains transmute into compassion. Chaplains who cultivate maturity, equanimity, and compassion, in part by practicing mindfulness, find greater resources to attune to the interior and exterior processes of their bodies. They develop capacities to attend to their bodies and with their bodies to the experience of self and other, constituted through interlinked yet differentiated human identities.

Collective Bodies on the Path

In response to the questions with which I began this chapter, if suffering cannot be avoided in the human condition, mindful chaplains find a way to use suffering that routinely takes place in biomedical settings as the means by which to cultivate wisdom. They view the hospital as a charnel grounds that teaches attuned human eyes and ears to see and hear the wisdom inherent in human suffering, which is the consequence of the truth that there is no permanent refuge in any of the shifting sands of phenomena. Health and wellbeing, though highly desirable, are fleeting

---

[42] Daniel Goleman and Richard Davidson, *Altered Traits*, 78.

[43] This phrase came out in each of the four conversations I had with Freeman. "Bearing witness" figures as one of the practice descriptions for his spiritual caregiving that Freeman most frequently uses, which directly descends from Glassman's formulation of the ZPO's Three Tenets. For reasons I outline in the introduction, this action of bearing witness espoused by Glassman and Freeman has obvious affinities, *mutatis mutandis*, with vulnerable observation in anthropology and sociology. For bearing witness in vulnerable observation, see Art Bochner, "Narrative's Virtues," *Qualitative Inquiry* 7 no.2 (2001): 131-158; Art Bochner and Carolyn Ellis, *Evocative Autoethnography: Writing Lives and Telling Stories* (Walnut Creek: Left Coast Press, 2016); Ruth Behar, *The Vulnerable Observer: Anthropology That Breaks Your Heart* (Boston: Beacon Press,1996); Arthur Kleinman, *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger* (New York: Oxford University Press, 2006); Arthur Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995); and Paul Stoller, *Stranger in the Village of the Sick: A Memoir of Cancer, Sorcery, and Healing* (Boston: Beacon Press, 2004). The entirety of these literature bears the the identifying marks of Romanticism, such as notions of authenticity, integrity, responsibility, and normative self-expression.

and true joy cannot spring from clutching them or craving them in a grasping and covetous way. Seeing the truth of impermanence requires a certain degree of spiritual maturity, which comes in the wake of grief and loss. When the clinical chaplain squarely faces her griefs and losses and makes sense of their disordering presence in her interior life, she can regain a sense of the mystery of her own shadowy depths. She can find the fruitful darkness within herself that will guide and strengthen her spiritual caregiving. To do this work of locating her inner mystery requires the cultivation of somatic modes of attention in order to be able to heed the body as an object of thought and see through the medium of the body (perceive with the body) with greater clarity and nuance. Halifax's GRACE model of compassion, and the incorporation of mindfulness into spiritual care more generally, is one means by which to accomplish the reshaping of embodied dispositions through spiritual practices. Clinical chaplains trained at UZC are in the midst of reinventing Zen traditions at the same time as they are responding to self-identified needs of biomedical systems like hospitals and hospices. Successful clinical caregivers, including chaplains, engage in the cultivation of values like empathy, relational communication, attuned and attentive listening that a burgeoning research literature on compassionate care indicates improves caregiving in terms of quality, cost-effectiveness, and retention of caregivers.[44]

The research literature also suggests that patient and family views on compassion have not received the exploration they deserve. This means that even though compassionate, patient-centered care is considered the ideal, very few systematic qualitative studies exist that analyze what compassion looks like from the patient point of view.[45] While assertions about compassion's salubrious influence in healthcare institutions are compelling, more rigorous qualitative studies need to be done in healthcare institutions to reveal patient and family perspectives on compassionate care, so that caregivers can use these data to design caregiving that centers on patient and family needs. While many authoritative voices in Zen Buddhism teach about the naturalness of compassion, it is rather likely that patient views of compassion will disclose nuances that Zen teachers have not captured. Only more research will reveal if Maull's view on compassion's dual sense as value and experiential truth holds true for patient experience: "At one level we can say that compassion is a value, but at another level—and according to Buddhist teachings—we can say that compassion is the experience of non-separateness. We become conscious of non-separateness and not in a way that is confused about boundaries." From the Zen perspective, wisdom reveals that all boundaries between selves are constructed, and therefore we all live and breathe in one interconnected organism, and compassion is the natural sequel of this wisdom. But is this how most patients understand compassion?

---

[44] Sinclair et al., "Compassion."

[45] Sinclair et al., "Compassion In Health Care."

For obvious reasons, a model for best practices in collaborative compassionate care that is "patient-centered" will require gathering data on what patients and families understand compassion to be.[46] Another angle of critique centers on the creation of a hero-villain dynamic, the dominant identities of mindful caregivers in conflict with the administrators of dehumanizing medical care in rescue of the victimized patients and families. The discourse of pathological altruism highlights the awareness of Zen chaplains with regard to their tendency to self-mythologize. Who gets to tell stories of spiritual caregiving, for what purposes, and to what effects? Who is held responsible for caregiving, and how are certain actors absolved of culpability? What kinds of dominant identity create what kinds of shadow selves? In the collaborative work of medicalizing mindfulness, the linkage across religious, research, and biomedical institutions reinforces the power of Zen meditation experts, neurobiological researchers, and mindful clinicians who imagine and embody empathy, compassion, and resilience across lines dividing religion and secular biomedicine. Bodies ritualized to provide mindful spiritual care become the means of empowering caregivers to resist and transform moral distress into moral resilience. But this can transform them into the heroes of a saga that pits them against the enemies of the ethical provision of care, ostensibly hospital administrations that optimize efficiency and profit at the expense of providing the best care possible. A Zen chaplain's way of telling this hero narrative may perpetuate problems, making sure that her help is continuously in demand by reinforcing agonistic relationships, rather than solving problems through the creation of solidarities that dissolve conflict.

Patients and families might understand compassion in a differentiated way that shows why their grief and suffering are the existential core of illness experiences and the narratives that human beings tell about them. Many patients may resonate more with an image of compassion communicated by the phrase: Jesus wept.[47] The narrative context of Jesus's weeping in the Gospel of John is his reception of the news that his friend Lazarus died, and he weeps even though he has the power to bring Lazarus back to life. According to chaplains and persons experiencing their own personal loss, the value of compassion—and its phenomenological truthfulness—may emerge from the wounded weeping of grief just as much as it would from an open,

---

[46] Kathryn Pfaff and Adelais Markaki, "Compassionate Collaborative Care: An Integrative Review of Quality Indicators In End-of-Life Care," *BMC Palliative Care* 16 (2017): 2.

[47] John 11:35.

objective, and observing mind decentered from the self.[48] In either version, the self who weeps or the self who resonates with pain in more understated way, the self extended into affinities with others is not a self without heart. Rather it is a self extended beyond the conventional boundaries of the body into the filaments of webs of care for others. The extension of mindfulness practices into clinical encounters and research on clinical care may lead not only to the development of spiritually-inspired values in caregiver, but also to methods of providing care and conducting research that enable patient views on compassion in medical encounters to weigh in more forcefully in the constitution of medical care.

---

[48] For neurobiological descriptions of "decentering," see Daniel Goleman and Richard Davidson, *Altered Traits*, 196; Francisco Varela, Evan Thompson and Eleanor Rosch, *The Embodied Mind: Cognitive Science and Human Experience* (Cambridge: MIT Press, 1991), lxiv; Anthony Lutz et al., "Investigating the Phenomenological Matrix," 640; Kirk Bingaman, "Incorporating Contemplative Neuroscience and Mindfulness-Based Therapies Into Pastoral Care and Counseling: A Critical Correlational Method," *Pastoral Psychology* 65 no 6 (2016): 769-770; David Vago, "Mapping Modalities of Self-Awareness in Mindfulness Practice: A Potential Mechanism for Clarifying Habits of Mind," *Annals of the New York Academy of Sciences* 1307 no. 1 (2014): 38; and John Dunne, "Buddhist Styles of Mindfulness: A Heuristic Approach," in *Handbook of Mindfulness: Culture, Context, and Social Engagement* eds. Ronald Purser, David Forbes and Adam Burke (New York: Springer, 2015), 252. I will offer an example of decentering in clinical practice in chapter six when I discuss Rob Adrian's adaptation of Tara Brach's framework to clinical chaplaincy.

Chapter 6

Translating Mindfulness: From Sitting to Acting

> Learning the language of the body is much like learning a foreign language. The language of the body has its own grammar and syntax and idioms, and there's no way to learn it in just one day.
>
> —Peter Levine, *Healing Trauma*

As they interface with modern medical institutions, clinical chaplains trained at UZC primarily translate practices between contexts through the medium of the body as the dwelling place of desirable traits, the embodied values (*paramitas*) of American Zen. In institutions of clinical care like hospitals and hospices, chaplains must cross between the differentiated spheres of religious communities and biomedical contexts; they are also trained to dwell in the bodily schema and experiences meditation fashions in the mindful body and embodied mind. In this form of crossing and dwelling both actions are oriented to enhancing compassionate care, often through small and incremental changes in embodied awareness and clinical routines. In the chapter that follows, I will retell stories that relate how clinical chaplains carry mindfulness practices across institutional boundaries through their embodied traits of stillness, equanimity, and compassion. Chaplains translate the embodied lessons of the Zen retreat setting into their professional settings in order to infuse clinical institutions with values such as compassion that they perceive would improve the care being provided in biomedical institutions. Embodied practices of mindful spiritual care permit the transfusion of Zen values into dispersed biomedical settings.

In this chapter, I will describe how UZC's meditation practices transform the mind-body relationships of chaplains and other clinical caregivers. I will explore how this mind-body transformation is interpreted as the primary means to transform social institutions, through the embodiment of values such as compassion, equanimity, and wisdom in chaplains and other clinicians. It is the reawakened body as it connects to the attuned mind of chaplains that provides the means by which the distributed community of chaplains at UZC critically engage with healthcare institutions in late modern US society. In Zen Buddhist language, mindful hospital chaplains embody the ability to bear witness to whatever joy and pain they encounter in the clinical setting without clinging to positive events or avoiding negative ones. Historian Winnifred Sullivan provides a rich description of how the practice of the Eucharist informs the spiritual presence of late modern Christian chaplaincy, which has emerged from modern Protestantism but has moved far beyond

its Protestant Christian moorings.[1] My research indicates that Buddhist chaplains also greatly prize the capacity to be present to suffering, but they do so from a different cosmological starting point. Both Buddhist and Christian chaplains nonetheless embody, to greater and lesser degrees, receptivity to patient experience. In a way that contrasts with other chaplains based in monotheistic faiths, Zen Buddhist chaplains trained at UZC have increasingly scaffolded their understanding of the work of "being present" in neurobiological terms.[2] The effect of developing discourses of explanation that draw on neurobiological research is the medicalization of meditation practices. To describe the beneficial effects of *zazen* and mindfulness in neurobiological terms empowers Zen chaplains to incorporate spiritual disciplines inspired by Buddhism into caregiving routines in clinical settings. It dissolves the barrier between Buddhism and science, making it appear is if American Zen Buddhism is a scientific religion or a science of the mind, a perception that is distinctly modern and different from many other forms of Buddhism practiced in Asia before the modern era.

Finding Stillness in the Fray: Clinical Pausing

The practices of care in late modern medical institutions express various logics, and these logics are influenced by social networks, organizational fields, religious cultures, and political economies outside of medicine. Astute observers of hospital systems have recognized how insurance companies and the single provider system for the elderly influence how medical providers furnish medical care, often to its detriment.[3] As I discussed in Chapter 2, the historical narrative of religious reading practices and seeker spirituality in the twentieth century underscores that communities of religious practice nourished hybridizers of spiritual psychologies, who then shaped the practice of pastoral care in modern hospitals. These spiritualizing psychological frameworks also showed the attractiveness of "naturalizing" spiritual values in modern and late modern medical practice. Teachers of American Zen like Roshi Joan Halifax have capitalized on this preparing of medical institutions for spiritual messages spoken in a scientific idiom that assemble what Erik Braun describes as an enchanted (inspired) and naturalized spirituality shot

---

[1] Winnifred Sullivan, *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014), 173-191.

[2] This is a point of view that is largely absent from the historical-critical or sociological literature on chaplaincy up until this point in the history of the study of spiritual care.

[3] Sharon Kaufman, *—and a Time to Die: How American Hospitals Shape the End of Life* (New York: Scribner, 2005).

through with Romantic influences.[4] As two iconic figures in the medicalization of mindfulness, Halifax and Maull have extensively dialogued with neuroscience researchers, and they would claim that they have incorporated empirically supported knowledge about how mindfulness and *zazen* cultivate empathy, compassion, equanimity, and lovingkindness. They assert these are qualities of a healthy mind that emerge when fearful patterns of thinking and feeling are stripped away to reveal the mind's empty but luminous essential nature. From this point of view, Zen clinical chaplains are poised to serve as the paradigmatic ambassadors of enchanted, naturalized mindful spiritual care. Dwelling in spiritually-inspired mindful bodies, Zen clinical chaplains enhance their powers to cross into and profoundly affect late modern medical contexts. What I am after below is offering a description of this translation work. In the section that follows, I explore how caregivers initiate subtle changes in caregiving practice in medical contexts. These changes begin with something as humble as the "clinical pause"—which means holding silence for a minute after a patient dies to honor their dignity as a person.

Numerous stories relate how mindful chaplains and clinicians creatively shape ordinary life through incorporation of meditative practices. UZC is a nexus of such translation of mindfulness practices into daily regimes at home or in the clinic. UZC's version of the story goes: intensive practice at UZC begins to alter the character traits of chaplains, rendering them more compassionate, empathic, equanimous, and loving through intensive sitting mediation and other Zen rituals, and then chaplains live and work mindfully outside of this religious context. As chaplain Liz Farmer explains, the first year of chaplaincy training focuses intensively on the work of inner chaplaincy. A chaplain trainee at UZC brings all the various internal resources and experiences she has to the retreat space. She does so in order to rework these internal resources, so that she can attune her empathy and compassion, along with their correlative neural circuitry, with the needs she intends to serve in her institutional context. She might discover, along the way, the pathological aspects of her own identity and counteract them with a spirit of lovingkindness. Every practical regime has its logic,[5] and UZC provides the grounded space in which chaplains train their awakened awareness on the implicit bodily meanings that inform their schematic orientations to the social contexts in which they work. In most social institutions, these logics are operant but often not explicitly expressed or conceptualized. In contrast, the chaplains trained by UZC engage in a process by which they make their own logic of care explicit to themselves, providing themselves with the means by which to monitor and modify their own caregiving practice.

---

[4] Erik Braun, "Mindful but Not Religious: Meditation and Enchantment in the Work of Jon Kabat-Zinn," in *Meditation, Buddhism, and Science*, eds. David McMahan and Erik Braun (Oxford: University of Oxford Press, 2017), 196-197.

[5] Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (London: Routledge, 2008), 2.

A number of my interviewees, who attended retreats at UZC and then returned home to translate practices back into medical institutions, did not complete the chaplaincy training. There are many reasons why chaplains who participate in trainings at UZC do not complete the full two-year program. For instance, Rob Adrian and Don Moore already had sufficient training for board certification but wanted to augment their skills in contemplative methods. I found myself needing more grounding in contemplative methods, but I had adequate theological training to begin a CPE residency. Farmer reported that some students drop out of the program because of its academic-experiential rigor or financial constraints. Some were caregivers in different roles in medicine. Not all the chaplains with whom I talked, who benefited from UZC's training protocols, completed UZC's two-year program. UZC welcomes chaplains and caregivers who want to attend Zen trainings in end-of-life care who do not intend to complete their chaplaincy training program. Trainings are open to caregivers who are not Buddhist but want to integrate contemplative practice into their caregiving. The leadership at UZC offers training to doctors, nurses, and other clinical caregivers who do not primarily serve as chaplains. Many of the chaplains influenced by UZC attended one of its better-known retreats like Halifax's "Being with Dying." For example, chaplains Rob Adrian and Don Moore both participated in "Being with Dying" in the past decade, and both are liberal Protestant chaplains with years of experience under their belts before attending. Named the director of the Compassionate Care Initiative (CCI) at the University of Virginia School of Nursing in 2015, Tim Cunningham attended trainings at UZC in 2010. Cunningham completed an advanced degree in nursing. He assumed leadership of CCI in 2015 when Susan Bauer-Wu departed to head the Mind and Life Institute. Though he did not complete multi-year training at UZC, he remarked on how important the training he did receive at UZC was for him when he went to serve the population of Sierra Leone during the Ebola outbreak from late 2014 to early 2015.

Cunningham remembered the traumatic intensity of the misery in Sierra Leone, saying "there was so much pain and suffering there that I was using practices all day, every day. I was using *tonglen* and other things that Roshi Joan taught us at Upaya." The vastness of the suffering threatened to overwhelm him, so in his need he practiced what he remembered from the retreat setting. As he notes, the current terminology for utilization of such practices in the world of clinical nursing might be Integrative Nursing or Complementary Alternative Medicine, but at the time practices seemed more important than the labels used to index them. "All we had were these things we were taught to do, we just didn't call them by the names that have become popular." The practice of articulating implicit social logics may serve the strategic interests of caregivers in institutional contexts that require a justification for the logics of care. In the midst of the intense suffering of the Ebola outbreak, however, deftly using contemplative practices that helped him to recruit his full human capacities to compassionately confront and transform interpersonal and

personal suffering seemed more pressing to Cunningham. Categorizing, justifying, or defending such practices, contemplative or otherwise, in moments of calm rational debate has its place. So does acting spontaneously to assuage harms when debate or reasoning are unfitting responses to the circumstances one confronts.

Under the leadership of Susan Bauer-Wu from 2013 to 2015, CCI established a strong relationship with UZC, sending many doctors, nurses, chaplains, and other clinicians to train under Roshi Halifax. The close connection between Halifax and CCI continues, to which her deliverance of 2019 Bice Lecture in honor of CCI's tenth anniversary attests.[6] Crossing from medical context to retreat setting, Bauer-Wu, as a master of her craft, has taught at UZC, most notably as part of nineteen-part series in July 2010 entitled "Zen Brain," in collaboration with scientists Laurie Leitch, Shauna Shapiro, and James Austin. UZC is a crystallization of larger social forces that make interfaith dialogue a desirable feature of religiously liberal communities. It is a place of open-minded, rational discourse, held in the frame of silent sitting meditation, about religious practices and altered traits. The mixing of traditions between Buddhist schools of thought in the United States and between religions characterizes religiously liberal late modern approaches to spiritual and religious practice broadly. Seager notes this religious liberal quality of American Buddhisms that include traditions inspired by Zen, *vipassanā*, and Tibetan meditation forms. "This eclectic and pragmatic approach comes naturally to Americans," he says, "who as a general rule, value personal religious experience highly but have little use for doctrinal consistency or patience with traditional orthodoxy."[7] Practical eclecticism aptly describes the approach of Halifax and the legacy she has created at UZC as one of Glassman's foremost *dharma* heirs.

A practical synthetic program inspired by secular mindfulness practices defined the early years of the CCI.[8] In a study conducted on CCI's program, Bauer-Wu and then Dean of the School of Nursing, Dorrie Fontaine, proposed the CCI as a model for developing resiliency and compassion in nurses in medical systems. They identify four values that guide CCI's interventions: "resilience, mindfulness, inter-professional collaboration, and healthy work environment."[9] The first two values relate to inner traits cultivated in caregivers. The second two values relate to

---

[6] Christine Phelan Kueter, "Mar. 13: Upaya Founder Joan Halifax to Speak," UVA School of Nursing, January 10, 2019, https://www.nursing.virginia.edu/news/roshi-joan/.

[7] Richard Hughes Seager, *Buddhism in America* (New York: Columbia University Press, 2000), 218.

[8] Spiritual caregivers should keep in mind that secular mindfulness always drags into secular institutions implicit Buddhist cosmological frameworks, which Buddhism holds accurately depict phenomena. See Candy Gunther Brown, "Can 'Secular' Mindfulness Be Separated from Religion," in *Handbook of Mindfulness: Culture, Context, and Social Engagement* eds. Ronald Purser, David Forbes and Adam Burke (New York: Springer, 2016), 84-85, especially her description of "Trojan horse" tactics in MBSR.

[9] Susan Bauer-Wu and Dorrie Fontaine, "Prioritizing Clinician Wellbeing: The University of Virginia's Compassionate Care Initiative," *Global Advances in Health and Medicine* 4 no. 5 (2015): 18.

interpersonal dynamics between caregivers. First, the authors formulate resilience as having the ability to be one's best self in the clinical setting, despite systematic obstacles to embodying one's values. While the definition of resilience they offer obscures the sense of being able to reintegrate after conflict or failure, it does indicate a nurse's fortitude in the face of distress. Nonetheless, resiliently overcoming challenges is vital to providing unstinting care that honors human dignity. Second, the authors argue that mindfulness increases nurse response flexibility and the left shift—from the right to left hemisphere in the cortex—in cognitive and emotive processing that correlates with an approach mentality. For the purposes of the CCI, in a way that shows the sway of Mindfulness-Based Stress Reduction (MBSR) in its own elaboration, mindfulness means "paying attention on purpose and nonjudgmentally."[10]

Paying attention to present moment experience with a stance of curiosity and openness entails "critical self-reflection in understanding one's values and biases."[11] Here it is worthwhile to highlight that Bauer-Wu and Fontaine are pointing to the self-monitoring processes that they believe mindfulness practices instill in them. The essential link that the authors make is that mindfulness practice leads to a fresher mind. That is, "by being more mindful, the nurse or doctor can better attend to each person and situation with fresh eyes and ears, thus sharpening essential clinical skills of assessing, diagnosing, and treating and providing safe, high-quality care."[12] This is because, Bauer-Wu and Fontaine argue based on neuroscience studies, mindfulness practice freshens attention: "it cultivates a continuous nonreactive awareness of whatever arises in experience."[13] Neuropsychologist Daniel Goleman and neuroscientist Richard Davidson assert that mindfulness disentangles nurses from surges in emotional payoffs of attraction or repulsion that distract them, and enables the integration of multiple self systems. These self systems can align in their orientation to core values in creating a sustainable work environment in which compassionate action is the norm rather than the exception. Creating such a clinical environment is the collective work of caregivers across disciplines and roles within a healthcare system. Thereby, resilient and mindful caregivers constitute a collaborative community of medical care, which in turn enables the work environment to achieve sustainable conditions.

---

[10] Ibid. Compare this to the view of Jon Kabat-Zinn, *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (New York: Bantam Books, 2013), xxxv. He writes, " I define mindfulness operationally as *the awareness that arises by paying attention on purpose, in the present moment, and non-judgmentally,"* his emphasis.

[11] Bauer-Wu and Fontaine, "Clinician Wellbeing," 18.

[12] Ibid.

[13] Daniel Goleman and Richard Davidson, *Altered Traits: Science Reveals How Meditation Changes Your Mind, Brain, and Body* (New York: Penguin,2018), 135.

Various levels of programming have allowed CCI to spread the value of compassion throughout the University of Virginia Health System (UVHS). Compassionate Care Ambassadors embody the core values of whole-person care and resilience. When I was a student in residence from the fall of 2014 to the spring of 2015, the program was still going strong five years after its inception. Drop-in resiliency activities like yoga, mindfulness, and tai chi took place several times a week in special rooms that have lighting and equipment to support contemplative practices. These rooms provide the space for 157 participants to engage in spiritual practices that CCI's founders assert cultivate resiliency. It is important to signal that the spiritual practices integrated into CCI programming all derive from East and South Asian religions, but they do nonetheless promote holistic caregiving. "The Melton D. & Muriel Haney Inter-Professional Conference: Compassionate Care at the End of Life," a biannual conference, has developed into a regional professional event for caregivers that is in high demand. Resiliency retreats teach healthcare workers to engage in spiritual care through "experiential stress-reducing practices and thoughtful discussion on the importance of self care."[14] On the academic side, coursework associated with the CCI has provided meaningful professional and personal development as an outcome of intensive practice and self-reflection. Like American forms of Zen in the wake of Thich Nhat Hanh's pervasive influence, these courses combine mindfulness and compassion as mutually reinforcing spiritual values. From its very beginnings in the spring semester of 2010, the CCI has naturalized the link between mindfulness, compassion, and skillful medical care in its program design.

Before the program received its official title, several key players gathered after the University of Virginia School of Medicine and School of Nursing received $3 million in funding from Tussi and John Kluge in 2010. Fontaine was instrumental in orienting the mission of the initiative during the two-day workshop entitled "Alleviating Human Suffering through Compassionate Care," which was led by former program director for the United Nations Dr. Monica Sharma. The workshop brought together the leadership of the initiative, including David Chattell-Gordon, director of the Community Engagement and Rural Network Development at the University of Virginia Health System (UVHS), Professor Daniel Becker, director of the University of Virginia Center for Biomedical Ethics and Humanities, and Fontaine herself. Other luminaries in the field of compassionate medical care attended, including Cynda Hylton Rushton who holds a chair that combines nursing and ethics at Johns Hopkins University. Jon Kabat-Zinn led a series of workshops in coordination with the inauguration of the program from March 11th to March 16th,

[14] Bauer-Wu and Fontaine, "Clinician Wellbeing," 20.

2010.[15] Since its inception, innovators in the practice of compassionate care that have bridged between American Zen religious communities and compassionate caregiving in medical settings, most importantly Rushton but also Kabat-Zinn and Halifax, have participated in and shaped the quality of compassionate care provided by CCI.

CCI and the contemplative retreats on clinical practices organized by UZC such as "Being with Dying" focus on establishing and maintaining clinician resilience in the face of distressing practices in medical systems. As UZC's website says of the 2015 "Being with Dying" retreat, "This unique program provides clinicians with essential tools for taking care of dying people with skill and compassion, as well as sustaining resilience and dedication as they serve others."[16] Bauer-Wu and Rushton are engaged in an ongoing dialogue with Halifax, interacting with her in structural and conceptual dimensions of caregiving practice, and both women have given instruction on compassionate caregiving at Halifax's "Being with Dying" retreats at UZC.[17] In collaboration with them, UZC has designed retreats intended to augment "moral resilience," in order to help caregivers cope with "moral distress" associated with forms of treatment that distress caregivers, such as what is called "futile" treatment that prolongs patient suffering or other biomedical practices caregivers view as unethical. In a coauthored article written in 2013, Rushton and Renne Boss remark that "moral distress reflects the deep commitments and value conflicts that accompany caregiver roles and complex patient and family situations" caregivers often confront.[18] The moral distress of caregivers in late modern hospitals has required a variety of innovative caregiver responses, notably the reinvention of contemplative traditions through intensive retreat programs. These training programs embody the dominant mode of compassion research as identified by Shane Sinclair and colleagues: they focus primarily on provider views of what compassion is and how compassionate care enhances caregiving, caregiver wellbeing, and caregiver resilience.[19] They are centered on endowing care providers with greater resilience through the practice of caregiver compassion.

The CCI is primarily designed to give providers greater capacity to develop sustainable clinical regimes that counteract nurse burnout. As Bauer-Wu and Fontaine report, many nurses who

---

[15] Dory Hulse, "U.Va. Schools of Nursing and Medicine Building a Transformational Model for Compassionate Care Worldwide," accessed December 12, 2019, https://news.virginia.edu/content/uva-schools-nursing-and-medicine-building-transformational-model-compassionate-care.

[16] Bauer-Wu and Fontaine, "Clinician Wellbeing," 20.

[17] "Being with Dying Professional Training in End-of-Life Care May 2013," Upaya Institute and Zen Center, accessed December 14, 2019, https://www.upaya.org/program/?id=885.

[18] Cynda H. Rushton and Renee Boss, "The Many Faces of Moral Distress Among Clinicians," *Narrative Inquiry In Bioethics* 3 no. 2 (2013): 89.

[19] Shane Sinclair et al., "Compassion: A Scoping Review of the Healthcare Literature," *BMC Palliative Care* 15 (2016a.): 1-16.

have participated in the trainings and coursework designed by faculty connected with CCI report greater self-compassion as a result of their training. The practice of reflective writing and narrative medicine in the development of self-compassion is especially well supported by research. For example, gaining insight into himself through reflective writing was one of Cunningham's preferred methods. When I interviewed him in April 2018, he applauded Bauer-Wu's contribution to laying a solid foundation for the CCI. He recognized the value of injecting more compassionate care into medicine and medical education, protecting the University of Virginia Health System (UVHS) from nurse apathy and burnout. At the same time, he says that CCI's current programing is moving in a slightly different direction, focusing on existing assets caregivers have rather than on the presence or absence of mindfulness in care. CCI is attempting to document all the various practices that clinicians typically access in daily clinical routines or at home, rendering their logics explicit. Before recommending any shift or change in regimes of practice, CCI wants to understand the resources which clinicians habitually apply to clinical problems. Soon after he assumed leadership, CCI developed an "assets focused model" instead of focusing their attention on what was absent in the clinical setting. As he puts it, they are looking to build on "approaches people are taking that enhance compassionate care."

In a recent survey, CCI found that many clinical caregivers listed activities they consistently practiced that were not included in existing defined categories of the study. In an open field on the survey, caregivers were invited to name ways they practiced self-care. For instance, they listed relaxing with family, reading the Bible, or praying. This leads Cunningham to the conclusion, "I think people are actually practicing, but not calling it self-care." His description of looking for the assets that clinicians bring to bear on clinical problems points to CCI's process of bearing witness to the ingenuity of clinicians before suggesting any form of repair. If one lets go of the notion that medical institutions need fixing, one might be able to discover what is in place that already works well but merely needs more systematic support. The shift toward taking stock of assets before suggesting that clinical staff take up any external practices puts into practice the kind of letting go of preconceived notions with which the Three Tenets begin. Cunningham further elaborates, "We need to be curious about what people are doing and provide support for the practices they already have." Under his leadership, CCI has incorporated the structure of the Three Tenets into its organizational culture, letting go of the impetus to critique, bearing witness to the resources in place, and acting compassionately to support already existing self-care practices. In finding that many caregivers already practiced self-care in a way that they themselves were not tracking well, CCI reformulated its approach, letting go of the notion that mindfulness practices were preferable, so that they could bear witness to the modes of resilience, and their logics, that nurses are practicing. In this way, Glassman's teachings have become implicit to CCI's organizational program.

At UVHS, one of the most effective practical adjustments that contemplative chaplains have made is to refrain from action and maintain silence when a patient dies for a minute or more, which is sometimes called pausing.[20] As one of the important shapers of CCI, Rushton's influence clearly shows here. In a 2009 article for nurses in advanced clinical care, she urges clinicians to pause in this way: "when an ethical conflict arises, it is often accompanied by heightened emotions, strained communication and relationships, and a sense of urgency to do something to relieve the conflict or discomfort. In the space created by a pause, there is an opportunity to slow down the urgency of the situation."[21] The application of the pause has proven instrumental in changing cultures of caregiving in various clinical settings where Rushton has worked throughout the nation. In many places, the inertia of treatment regimes leaves little room for grieving. The pause is a stark and simple intervention. At UVHS, critical care nurse John Bartels first translated the practice of taking a moment to honor the dignity of life into the Emergency Department culture. He explains, "the pause is a practice of honoring someone who has passed and using silence to do it."[22] Rather than signaling the patient's expiration and moving to the next room without any gap, pausing allows a clinician to make a sacred moral space in which to show respect for the passing of a human life.[23] When Bartels takes a pause, he and the other clinicians who join him engage in a practice of experientially recognizing and accepting human mortality. Pausing has been used to great effect in various Buddhist teachings, because it shares with letting go a preference to attend to inner experience without reacting to it. For instance, meditation teacher Tara Brach suggests the "sacred pause" is the "first step in the practice of radical acceptance."[24] Pausing is a means by which to open up possibilities of action one might never have

---

[20] Daniel Siegel, *The Mindful Brain: The Neurobiology of Well-Being* (Boulder: Sounds True, 2011a), Chapter 1, Audible. Siegel names this capacity to pause and then choose between several actions when confronted by a challenging event, "response flexibility." He describes the concept as a function of pausing after one has received multiple sensory inputs, asking "can you take in various things and then pause before you act? Can you pause before you act? Just think about that simple concept." Siegel proposes that mental process creates brain structure through patterns of awareness, and he names the lateral prefrontal region as the essential brain structure for creating a gap between information gathering and action.

[21] Cynda Rushton, "Ethical Discernment and Action: The Art of Pause," *AACN Advanced Critical Care* 20 no. 1 (2009): 108.

[22] Jonathan Bartels, "The Pause," accessed January 7, 2017, https://vimeo.com/143628865.

[23] Margaret Mohrman, "Ethical Grounding for a Profession of Hospital Chaplaincy," *The Hastings Center Report* 38 no. 6 (2006): 22. Mohrman refers to making "sacred spaces" in clinical chaplaincy as one of the primary responsibilities of clinical chaplains.

[24] Tara Brach, *Radical Acceptance: Embracing Your Life with the Heart of a Buddha* (New York: Bantam Books, 2004), chapter 3, Audible. The formal similarities with "letting go" are especially pronounced as Brach talks explicitly about pausing to let go of thoughts during meditation.

known, a way of discontinuing whatever reactions one might have habitually taken so as to re-frame events as they unfurl.

Besides in the event of a death, Rushton advocates clinical pausing whenever critical care patient-clinician dynamics threaten to destabilize. Pausing is "essential when ethical conflict arises. Slowing down the process can help create an environment in which mindful and intentional decision making can occur."[25] By pausing, clinical caregivers make space in which to slow down decision making to prevent end-of-life situations in the clinical setting from being hijacked by fight-or-flight arousal states. They believe they are able to notice patterns in interior process (action, thought, and feeling), monitor their own stance and deconstruct assumptions, and promote reflection and open inquiry while allowing space for new possibilities of interaction to emerge. As Brach says, "when we pause, we don't know what will happen next. But by disrupting our habitual behaviors we open up to the possibility of new and creative ways of responding."[26] In a similar way, Bartels drives home the salient need in clinical contexts to allow death to have meaning. "Before we walk away," he asks, "can we honor the life in this bed?"[27] The practice of the pause is about noticing and having reverence for the passing of a life, but does framing the pause as honoring life mean that practices of attending to dying patients that came before dishonored death? Bartels says the practice of pausing prepared him and other clinicians to meet each subsequent encounter with freshness. He claims that caregivers who pause accept the death they have just witnessed, which renews their attention and reduces their level of distress. When he pauses, Bartels believes he gives himself a better chance of being present in the next room he enters. In the words of chaplain Don Moore, a close collaborator of Bartels, the pause is necessary so that clinicians can see the next patient, "not as a problem, but as a person." Like Cunningham, Bartels attended trainings at UZC nearly a decade ago through the organizing efforts of the CCI, taking advantage of the close connection then established between Bauer Wu and Halifax. The pause is a fairly simple intervention, lasting a mere minute after each and every death, but the practice has had a noticeable impact in altering the practice of care within UVHS.

Bartels has been a tireless ambassador for the clinical pause in critical care units throughout the hospital system. For instance, Moore related how taking a pause reformed the caregiving culture well beyond the unit on which Bartels served. The practice of pausing instantiated a new caregiving logic, differentiated from caregiving practice that moves on after death automatically. Moore calls the pause "a simple ritual to honor someone's death." The ritual of holding silence for a minute honors the hard work of the entire clinical team to prevent a patient's death. It also

---

[25] Rushton, "Ethical Discernment," 108.

[26] Brach 2004, *Radical Acceptance*, Chapter 3.

[27] Bartels, "The Pause."

honors the human connection between caregivers, the deceased, and families. Accessing her own religious or spiritual tradition(s), each clinician present for the death takes a mindful or prayerful moment and honors the dead. Moore reports that over time the pause became a more formalized practice often employed in all caregiving, not just at death, throughout the hospital. "I started doing this as a practice in all my interactions throughout the hospital," Moore says, even though caregivers felt an acute need especially after the intense arousal states associated with attempting to save a patient. Spiritual caregivers and attuned nurses bring to their collective awareness the "feeling of relief and relaxation," after making every attempt to give proper care to the patient. According to Moore, the ritual of pausing provides the space in which clinicians can find their socio-emotional equilibrium again after a tumultuous storm. In the neurobiological view, pausing allows for pendulation after stressful, high arousal states.

The example of the pause shows how spiritual caregivers on the front lines in hospital systems are bringing logics of care undergirded by Zen practices to bear on institutional problems in medical institutions. Other examples of integrating Zen practices into medical care abound, such as Frank Ostaseski's application of Zen to end-of-life care and his integration of Zen teachings into his reflection on his practice. The longtime leader of the San Francisco Zen Center and the Metta Institute (MI) connects mindfulness with compassionate end-of-life care in his writings and practice. Ostaseski routinely teaches during a retreat designed to instill the principles of Zen end-of-life care into caregivers at UZC. He has also taught in other contemplative retreat settings like the Garrison Institute, where I heard him speak at a retreat for end-of-life caregivers in November 2018. He founded MI to "provide innovative educational programs and professional trainings that foster mindful and compassionate end-of-life care."[28] His book on Zen palliative care, *The Five Invitations*, describes his efforts over many decades to provide mindful end-of-life care and encourage greater receptivity to the spiritual lessons death teaches. In Ostaseski's view, mindfulness gives clinical caregivers the ability to fully engage in emotional life while not feeling bound to any phenomena they experience. That is, mindfulness enables "functional decoupling" in the spiritual caregiver—the separation of feelings, sensations, and cognitions related to care from personal identity.[29] These decoupled experiences can then be recombined with greater volitional control. Decoupling gives chaplains the ability to embody tender concern for others by not being flooded by negative empathic resonances. "With mindfulness," Ostaseski writes, "the

---

[28] Metta Institute, accessed April 20, 2018, https://www.mettainstitute.org.

[29] Goleman and Richardson, *Altered Traits*, 91.

mind becomes saturated with sensitivity and a balanced acceptance, opening and receiving the present moment just as it is, without clinging to or rejecting anything."[30]

Endowed with the stability of mind to encounter death less encumbered by reactive counter-transference, mindful caregivers attuned to patients are present to bear witness to death and its meanings, settling into a wise acceptance of the limitations of biomedical cures. Ostaseski continues, "We pause, we relax, and we allow. Our thoughts may wander, troubling feelings may unfold, but for once we are not trying to control, change, approve, or reject them."[31] In Ostaseski's practice, mindfulness provides the means to cultivate mindful self-compassion by deliberately and repeatedly abandoning the mechanisms by which society normalizes aspirations for self-mastery. That is, instead of evaluating herself or another, the chaplain relaxes into acceptance of self and other as the basis for therapeutic interventions. She allows whatever is coming up to enter the scene of the mind without resistance, which extends to her inward disposition toward her own experience or activities or those of others. As Ostaseski says, "mindfulness is not just inward looking. It can guide our outward actions."[32] Seeing clearly will likely translate into selfless acts. Inward looking and outward service couple to constitute Zen Buddhist ways of engaged social action.

Chaplain Don Moore remembered his trip to UZC in 2013 as the apex of his chaplaincy career, calling it a "culminating experience." He linked the push to reform caregiving culture at UVHS at the end of his term of service with his trip to UZC, explaining how CCI brought together nurses and physicians with spiritual caregivers, who were intentionally trying to improve the hospital culture. Various clinical staff were collaborating in order to "integrate wisdom and mindfulness into the work of the hospital." In his clinical work, Moore attempted to integrate the ethos of the pause into his interactions. Around this same time, UVHS's Director of Chaplaincy Services and Pastoral Education, Mildred Best, found grant money to pay for mindfulness meditation trainings for each of the six staff chaplains interested in integrating mindfulness into clinical chaplaincy practice. After they completed the mindfulness trainings, the chaplains met at the CCI to support each other's integration of mindfulness in their caregiving. Moore elaborated that through the incorporation of mindfulness, "we were trying to change practices in the hospital" to invigorate empathy for caregivers and patients alike. They began to hold memorial services each

---

[30] Frank Ostaseski, *The Five Invitations: Discovering What Death Can Teach Us About Living Fully* (New York: Flatiron Books, 2017), 205.

[31] Ibid. See also Kelly Raab, "Mindfulness, Self-Compassion, and Empathy Among Health Care Professionals: A Review of the Literature," *Journal of Healthcare Chaplaincy* 20 no. 3 (2014): 95-108; Kirk Bingaman, "When Acceptance Is the Road to Growth and Healing: Incorporating the Third Wave of Cognitive Therapies Into Pastoral Care and Counseling," *Pastoral Psychology* 64 no 5 (2015): 567 - 579.

[32] Ostaseski, *Five Invitations*, 205.

season to honor the memory of clinicians who died and create a deeper sense of community connection. The difference in approach and intention between Cunningham and Moore reveals the adaptability of practices like pausing, letting go, and bearing witness. At an earlier moment in CCI's history, incorporation of mindfulness practices in an explicit way appealed to clinical and spiritual caregivers. At a later moment, the practice of letting go became implicit to the organizational culture of the CCI. In either case, pausing to observe and take stock of experience as a sacred reality in a receptive way that dissolves reactivity has played a key role to the local logic of care at UVHS, expressing the ordinary enchantment of American Zen.

Bartels, Cunningham, and Moore are certainly describing an encounter between medical caregiving and mindful spiritual care in UVHS, but it is important that we recognize the firm boundary between biomedicine and certain genres of religious practice. It is worthwhile to ask, what types of religiosity never make it through the door of hospitals? Moore definitively points out the affinity of mindfulness practice with clinical institutions that assume normative values of self-possession: sound and sane human consciousness is in possession of itself. Based on this assumption, mindfulness is an interior process that ostensibly leads meditators to have greater capacities for self-regulation and self-integration. Mindfulness is not usually associated with more ecstatic rituals that many people associate with the indigenous practices of the Americas or African religions. Speaking of the value of religious practices to healing, Moore relates: "Ritual is a powerful tool. People have been using rituals for thousands of years. They have been dancing and drumming like the Monacans, or using song and prayer. I don't know if dance would work on the ward. Within the hospital system, we used mindfulness techniques." As Pamela Klassen and Courtney Bender assert in *After Pluralism*, encounters between religions in secular institutions or between religions and the secular institutions themselves display the disparity of cultural capital held by differentially situated religious actors.[33] While pluralism ostensibly offers equal protection in secular institutions for all spiritual families, secularism means that "all spiritual families must be heard,"[34] relentlessly modernizing reinvented religious traditions like American Zen obviously enjoy the privilege of being supported by the discourses of empirical neuroscience whereas most other spiritual families do not. That is, to become a Zen chaplain is to assume a dominant identity who dresses his practice in the emperor's clothes of empirical neuroscience discourse.[35] This is not to foreclose the good this kind of dominant identity can do in

---

[33] Courtney Bender and Pamela Klassen, *After Pluralism: Reimagining Religious Engagement* (New York: Columbia University Press, 2010), 15-17.

[34] Charles Taylor, "The Polysemy of the Secular," *Social Research* 76 no. 4 (2009): 1151.

[35] Eleanor Rosch, "The Emperor's Clothes: A Look Behind the Western Mindfulness Mystique," in *Handbook of Mindfulness: Culture, Context, and Social Engagement* eds. Ronald Purser, David Forbes and Adam Burke (New York: Springer, 2016), 271-292.

clinical settings or the possibility that future studies on other forms of spiritual practice will endow them with greater translatability into biomedicine. It seems likely that neurobiological study of centering prayer or choral singing will reveal that they have healing possibilities that in comparison with mindfulness are broadly similar in their benefit but subtly different in their effects

By claiming that the conventional self lacks permanence, Zen Buddhism does propose a model of personhood by which to imagine and experience an "extended self" that erodes Western conventions, norms, and views of self-constitution. In Zen, one's self is constituted in ongoing processes through which the substance of the self is in continuous flux. This view on the self echoes theories about the self in humanistic psychology advanced by Karen Horney and Erich Fromm. The incorporation of forms of American Zen Buddhist practice like pausing and bearing witness provides the practice space in which to destabilize late modern self-experiencing that fixed selfhood in the boundaries of the individual body and life narrative. One pauses by shifting one's attention into a non-active and receptive state in which one silently observes interior and exterior bodily processes for a short duration of time (between one and five minutes). To make pausing a habit inculcates new somatic modes of attention, bringing awareness to the processes of self-constitution in exteroceptive and interoceptive domains. Advocates of pausing like Pema Chödrön and Tara Brach hold that it promotes the integration of interior experience, making a bridge between identities and individual bodies available in open-hearted relationships that connect persons body-to-body and mind-to-mind. As Brach maintains, "we learn radical acceptance by practicing pausing again and again" at various moments of our life when we overcome our reactive tendencies to perceived threats.[36] That is, a chaplain can relax her boundaries in the context of threat, and then she can find that her self is thereby extended beyond the limits of her physical organism and her particular story.

In a clinical setting, a chaplain's tender compassion flowers from the ground of her receptive heart that she has trained through practices of sitting in stillness with her "own internal mental world."[37] Clinical chaplains inspired by American Buddhist teachings hold that in pausing they can remain face-to-face with their own fearfulness without fleeing. By pausing and softening their inner emotional stance, they train themselves to engage with the death of others, an engagement which might awaken the chaplain's fear of her own mortality. In opening her heart to face fear, a contemplative chaplain follows "a training in how to die."[38] Another way to say this is that in mindfulness practice, "there is a deep sense of dying, moment to moment" in and out of

---

[36] Brach, *Radical Acceptance*, Chapter 3.

[37] Daniel Siegel, *Mindsight: The New Science of Personal Transformation* (New York: Bantam Books, 2010), Introduction, Audible.

[38] Brach, *Radical Acceptance*, Chapter 7.

the clinical context.[39] In this way, when chaplains pause they open up a space for death to enter back into the fray of medical care and assert its value as a marker of unrepairable human suffering. The writings of Brach, Ostaseski, and Halifax embody the maturity in clinical practice Elisabeth Kübler-Ross identified as essential fifty years ago. "If we are willing to take an honest look at ourselves," she writes, "it can help us in our own growth and maturity. No work is better suited for this than dealing with very sick, old, or dying patients."[40] To pause and accept the lesson that death teaches about the ultimate inescapability of human mortality goes against the culture of heroically attempting to prevent death that medical anthropologist Sharon Kaufman reveals in her trenchant critique of medical systems. Kaufman argues that both ideological and financial logics prevent clinicians from caring for those persons that medical interventions cannot save. Among other caregivers keen to change how care is furnished to patients, American Zen chaplains are doing their part to change the logics of rescuer medical care based on an alternate view of dying and an alternative practice of self-making. They are proposing a vision of heroism based in the Zen approaches to dying and death. This is not to dismiss the benefits of Zen heroism, but to put them in critical perspective.

American Zen chaplains bear witness to the suffering that death denying produces in medical institutions. Kaufman describes the paradox of this suffering well. "Although most people die in hospitals," she writes, "hospitals are not structured for the kinds of death that people claim to want."[41] Kaufman posits that this is largely because of the fact that Medicare payments required medical institutions to ferry patients back and forth between hospitals and nursing homes, leading to patient dislocation, isolation, and more often than not neglect. Most commonly, financial policies related to insurance payments and reimbursements have predominantly determined the logic of care within large hospital systems. This leads Kaufman to conclude, "dying people are not wanted in medical institutions, and it shows."[42] In a parallel argument, Helen Stanton Chapple laments: "staving off death is the definition of legitimacy and of endorsable, reimbursable

---

[39] Joseph Goldstein, "Meditation Practice: A Practice of Dying," *Awake by the Bedside: Contemplative Teachings on Palliative and End-of-Life Care*, eds. Koshin Paley Ellison and Matt Weingast (Somerville: Wisdom Publications, 2016), 102.

[40] Elisabeth Kübler-Ross, *On Death & Dying: What the Dying Have to Teach Doctors, Nurses, Clergy & Their Own Families* (New York: Scribner, 1969), 47.

[41] Sharon Kaufman, *Time to Die*, 29; Helen Stanton Chapple, *No Place for Dying: Hospitals and the Ideology of Rescue* (Walnut Creek: Left Coast Press, 2010), 91-92; Chapple makes a similar argument in her book, pithily names the belief system that underwrites the regime of heroic medicine the "ideology of rescue" and describes how medical routines create a hierarchy of intensifying treatment techniques that clinicians use to ward of their aversion to death. She calls this ritual technology by which clinicians keep the existential threat of death at bay "the ritual of intensification."

[42] Kaufman, *Time To Die*, 29.

care in the hospital."[43] This means that often heroic medicine works by aligning the patient, family, and medical caregivers as guardians of the patient's body who fight against illness and death. What appears to be a reasonable and valuable aim that creates solidarity amongst all the stakeholders involved in care when curative arts are effective, paradoxically causes the patient to suffer isolation when the body fails to respond to curative methods and caregivers and family turn away from the failure of their collective efforts. Perhaps, Bartel's avid ambassadorship of the pause is an expression of a competing heroism, since pausing enables the caregiver to find the courage to honor death as a wise teacher. In this interpretation, what is emerging is a new narrative of heroic Zen chaplains who re-humanize death, defined by tributary stories in which clinicians use encounters with death as the beginning point of clinical wisdom.

One clear benefit of pausing is the disruption of routine ways of providing curative medical interventions, especially in circumstances when aggressive curative medicine is a poor treatment option. To pause and attend to what one sees opens up the pathway for clinicians to perceive alternate meanings of death, to, in the words of palliative care physician Ira Byock, "imagine people well" even in the process of dying.[44] Creative imagining can be a prelude to compassionate and collaborative caregiving. It gives clinicians a means to pay closer attention to the sociomoral values death elicits and raise questions about the meaning and purpose of human life. Kaufman, Chapple, Arthur Kleinman, and Arthur Frank each show in their own nuanced ways the tendency of medical institutions to fail to accompany patients and families as they wrestle with these questions of ultimate meaning.[45] Like Kleinman, one might call the harm caused by this structural incapacity of medical systems to attune to patient concerns a form of "social suffering." In Kleinman's terms, social suffering is an everyday form of harm that increases distress in ways that slip below explicit notice but nonetheless imprint the bodies of the seriously ill. Social suffering aggravates painful circumstances in bodily experience because patients are not enabled to generate self-awareness and integrate suffering through self-narration. Kleinman asserts that the value of attending to illness narratives derives from the integrative personal and interpersonal work that narration performs in holistic healing.

---

[43] Chapple, *No Place for Dying*, 90.

[44] Ira Byock, "Imagining People Well," in *Awake at the Bedside: Contemplative Teachings on Palliative and End-of-Life Care* ed. Koshin Paley Ellison and Matt Weingast (Somerville: Wisdom Publications, 2016), 281–297.

[45] Arthur Kleinman and Kleist Van Der Geest, '"Care' In Health Care: Remaking the Moral World of Medicine." *Medische Antropologie* 21 no. 1 (2009): 159-168; Arthur Kleinman, "Catastrophe and Caregiving: The Failure of Medicine as an Art," *The Lancet* 371 no. 9606 (2008): 22-23; Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988); Arthur W. Frank, *Letting Stories Breathe: A Socio-Narratology* (Chicago: University of Chicago Press, 2010). Frank, Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995).

Kleinman describes how such violence is delivered: "social suffering is the result of the devastating injuries that social force inflicts on human experience."[46] He elaborates further by calling the genre of violence that engenders social suffering "sociosomatic,"[47] which is to say that structural features of social worlds wound the body. Social violence, which invariably has somatic consequences, is not merely the property or problem of one autonomous, self-possessed person. It is the shared burden of collective groups of people who encounter each other in the public and private spheres of the late modern world. As chaplains, nurses, patients, and patient families travel between social contexts, they carry the imprints of such violence in their bodies and minds. Simple and habitual pausing provides a key temporal break, a first step, so that change in the provision of care might take place at the level of practice. To counteract distress, pausing cues the remembrance of the receptive stances of mind and body that reinvented contemplative traditions train into the flesh. One might consider hospitals places that heal and cure violence done to patients in the outside world. In some ways, the research of contemporary social scientists and ethicists argues against this view. They provide evidence that the systematic avoidance of mortality by hospital staff commits interpersonal violence of a psychosocial and sociosomatic kind. Pausing helps counteract these forms of insidiously silent social violence that Kleinman and others have named.

In fact pausing means attending to what comes up without an evaluative distinction between what is good or bad, desired or despised, moral or immoral. This is true whether the practice is informed by Buddhist views on the nature of the mind or a Christian theology of God's presence in and with us or some secular vision that aspires to embody the highest and best vision of what it means to be human. It may just be the first step toward greater compassion in UVHS and beyond, even if the process of change proves glacially slow. Along these lines, Cunningham urged me in our conversation to look toward the positive trends in medicine already begun that will take decades to ripen. He said with confidence that the "shift in making hospitals more compassionate will take the time it needs to take." It will be the result of a variety of smaller, incrementally building processes that come together and require training more resilient and compassionate caregivers while adjusting financial and social incentives in medical care. Such changes will certainly cause blindspots and have their unforeseen costs. As much as the pause may lead clinicians to recognize the value of death, Zen heroism produces its own forms of misrecognition.

Cunningham means to encourage a shift to compassionate care by paying close attention to what CCI finds on the ground in the form of practices that caregiving staff already bring into

---

[46] Arthur Kleinman, "The Violences of Everyday Life: the Multiple Forms and Dynamics of Social Violence," in *Violence and Subjectivity* ed. Veena Das (Berkeley: University of California Press, 2000), 226.

[47] Ibid.

play. Around these practices, he believes that building community in solidarity might prove the most important move, since linkages with other caregivers sometimes wither under the strain of caregiving routines and demands. Besides providing training related to leadership, resilience, and compassion, CCI is turning its attention to building stronger communities through retreats for entire units that do not necessarily focus on mindfulness teachings. "We are providing spaces for community to gather—colleagues, friends, and family to come together. Being together—togetherness—is very important. Togetherness holds people closer to their practices." If social suffering is a collective problem of the social worlds in which chaplains and nurses provide care, then it will only be solved through the collective efforts and resources of various communities of care strengthened by practices that promote interpersonal attunement, empathic resonance, and compassion.

Beginning with Silence: The Pause as Prelude to Clinical Rounds

Some proponents of mindfulness practices believe that small adjustments like beginning interdisciplinary rounds with mindfulness are not enough, a position staked out by my current mindfulness teacher, Bethany Crawley, who consults with hospital systems in the Jacksonville area about nurse resilience.[48] Others assiduously pursue the incorporation of mindfulness into small clinical margins. For example Chaplain Daria Bangler incorporates a brief mindfulness meditation into the clinical rounds of a palliative care unit in a large research hospital in the South. Under her guidance, the palliative care team ends their interdisciplinary rounds with a few minutes of silence, a brief clinical pause, in which the team members ground themselves in their bodily awareness. This momentary pause translates mindfulness practices into palliative care, which can provide the basic schema for self-aware action that lodges in the implicit memory system of the actors who begin their daily round with such remembrance if it is practiced with enough regularity. It cultivates character traits of equanimity in chaplains and clinicians engaged in such a practice, allowing them to pause, ground, bear witness, and then respond. She relates that part of her role on the team is to serve as prompt to contemplative practices: "I insist on finding time to make contemplative practices a part of each round we do." Having explained the value of her mindfulness practices as a way to help clinical caregivers to attend to clinical tasks, Bangler regularly cues the team to take a pause and bear witness. When she does, she usually invites the team members to direct their awareness to their breathing as the focal point of their

[48] Bethany Crawley, personal conversation with the author, October 20, 2019. Crawley owns Lotus Yoga with another yoga instructor and has begun a nonprofit that trains healthcare workers in mindfulness named The Healing Tree Project. She received her meditation training at Spirit Rock, but has a variety of influences in various modalities of spirituality.

attention and return to this anchoring point without judgment when their thoughts stray. The meditative moment typically lasts for about two minutes. Forgetting that Bangler will remind them to take a moment to silently follow their breath, sometimes team members shuffle papers at the end of rounding as they prepare to stand. Very often afterwards other clinical staff express their appreciation to Bangler for cuing this daily grounding moment, but the demands of routines and chronic time pressures often urge the clinical team to launch into the day without second thought.

In Bangler's absence, the palliative care team usually neglects to practice a silent pause. I later asked Bangler why the staff might decide consciously or unconsciously to begin their day without a pause, and she offered this insight, which she is quick to preface by indicating the speculative nature of her comment. "I don't know, but my personal theory is that the ego mind just does not want to stop. It is always looking ahead to its next task, and it does not want to slow down." My own experience collaborating with ICU staff at Baptist Health teaches me that every moment of the clinical day counts, and that intensive care nurses act with a sense of urgency especially in moments of crisis, which are the very moments when pausing could have the greatest impact. It is for this reason that Chögyam Trungpa Rinpoche, with his iconoclastic reframing, calls sitting meditation practice "wasting time."[49] He reasons that only in first wasting time can human agents make the most of the time they have. It is a deliberate act to frustrate self-defined aims that populate consciousness with objects of thought. One practices mindfulness in order to disengage from motivated behaviors that seek to satisfy one's need for a sense of accomplishment, the game of credentials. Bangler explains her own remembrance of taking a moment to pause when she started volunteering at Southern Dharma. The outcome of extensive training of her mental and bodily rhythms in a community of practice has integrated moments of pause in her biorhythms. She talks about the difficulty of starting to volunteer at a retreat center community as a deep dive into practice. Bangler shares how she went to an eight-week program to begin her mindfulness training where she completed several hours of mindfulness meditation practice every day. After finishing her formal practice for the day, she transitioned into cooking in the kitchen. Bangler relates that the first few months of daily practice consistently challenged her. But she stayed with it, and consistent repetition over three years of working as a cook in the Southern Dharma kitchen and two years of training at UZC habituated her body and mind to framing her daily routines with mindfulness.

Bangler's story of moving between several different retreats and social institutions reveals a common pattern of how mindfulness practices move from Buddhist communities into the wider late modern US context. The primary vectors of transmission of Buddhist and Buddhist-inspired

---

[49] Chögyam Trungpa, *The Path is the Goal: a Basic Handbook of Buddhist Meditation* (Newark: Audible, 2014) Chapter 3.

practices between Buddhist communities of practice and social institutions furnishing medical care are the bodies and embodied consciousnesses of clinical caregivers schooled in mindfulness, *zazen*, *metta*, and other contemplative modalities.[50] After taking time to pause, chaplains may find themselves having more patience when holding the hand of a demented patient chagrined from the irritated throat she cannot remember had a ventilation tube in it earlier in the day. They may find themselves more receptively listening to the tragic story of a patient and seeing with more clarity the line between empathy and empathic distress. They may empathize with the frustration of an angry mother, dissatisfied with the plan of care for her daughter, while also empathizing with the nurses who are annoyed by the same mother who places unrealistic demands on medical staff about her daughter's care. According to the logic of practice embodied in UZC, an intellectual understanding of clinical practice is necessary but subservient to the practice of ethical action embodied in the natural human responses of empathy and compassion. This is so because human actors are not thinking things, but rather feeling beings who think and use their thinking to orient how they care. The embodiment of spiritual presence has an interior and exterior modality of feeling and appearing. UZC claims to generate balanced and resilient chaplain bodies, instructed by mindful contemplation, that transmit an abiding sense of being receptively present.

Being present to receive the experience of patients stimulates social change. First, chaplains change their stance toward their own body-minds in order to achieve "experiential acceptance" for themselves.[51] This means that Zen chaplains learn how to receive their own experiences without judgment so they can also receive others without judgment. Second, based on my clinical experience, beginning the routines of the clinical day with a form of pausing enables chaplains and caregiving staff to respond more flexibly and receptively to patient experience. When I begin the day by paying attention to the subtle shifts of phenomena in the body, I prepare myself for the possibility of rapid changes in the clinical environment. As Bangler says, I hold the stories I have used to frame events happening in the hospital loosely, aware that they could change in an instant for better or for worse. I receive the sudden intuition that this family will accept their adolescent child is legally dead if I sit with them and pray for the miracle they want, and the preparation of the ground for this kind of intuition or heartfelt empathy is grounding in the wisdom of the body. This daily starting point enables the pattern of letting go, bearing witness, and responding with compassion to my own interior world to cue my mind and body to remain open to whatever I encounter to the degree I am able. As it has for me more often than not, the pattern

---

[50] I would include Mindfulness-Based Stress Reduction (MBSR) and other forms of contemplative practice like Trauma-Sensitive Yoga (TSY) that apply teachings formulated by Jon Kabat-Zinn on open and nonjudgmental present-moment awareness in the category of Buddhist-inspired practices.

[51] Bingaman, "When Acceptance is the Road," 571-574.

of making space to allow various feelings, thoughts, sensations, and images to play in consciousness without leading to any particular action can thereby become a dominant mode of awareness for clinicians.

Priming Calm: Analogous Modes of Pausing

Pausing is but one method for a Zen clinical chaplain to remember the roots of her energetic being in the relationships of religious communities. The clinical pause reminds a chaplain to pay attention to her connection with others in her religious community as a resource that she carries within her. The approach to building community that CCI has developed is something that seems to hold for many communities of contemplative clinical chaplains. As Rushton and Halifax frame the value of interpersonal support in *sangha*, a chaplain's contemplative practices sustained in a religious community provide the necessary grounding to cultivate emotional self-attunement and resilience. Rick Freeman envisions this process of deepening wisdom in scriptural terms and proposes an arboreal symbol for how practices strengthen human beings: "The more we are rooted in our practice, the greater our resilience. I always tell people that I am teaching to imagine themselves like trees. We sit down and root into the energetic fields of the earth. We grow down into the energy fields below us." The symbol might not be entirely unfamiliar to any person of faith who holds the Hebrew Scriptures sacred, as Freeman does, since he is a practicing Sufi in addition to completing his chaplaincy training at UZC. The Book of Psalms so conceives of those rooted in God's righteousness:

> They are like trees that grow beside a stream,
> that bear fruit at the right time,
> and whose leaves do not dry up.[52]

In Freeman's novel interpretation of this ancient metaphor for meditation practices, making stillness in oneself noticeable to awareness carves out an internal reservoir. This reservoir collects spiritual energies and feeds the fullness of self as it grows.

When chaplains ground in their own bodily presence, they may free themselves from the habits of mind that look for dramatic institutional changes and complicated intellectualized frameworks. Mindful spiritual care may find rather simple and small adjustments to improve caregiving. These small adjustments begin with her positioning of her own body. A chaplain's suffering, in part, derives from the hard lessons she learns in paying close, curious, and accepting attention to the body's language. In Freeman's understanding, the body can perceive the energy

[52] Psalms 1:3.

streams it draws into itself from the larger reservoir of the earth's energetic field. He understands this dynamic of energy as how God works in the world. As chaplains continually place their attention on the subtle flows of energy linking their bodies to the energy presence of other living beings, they gain a greater appreciation for how subtle actions can prove the most radical. Subtly radical change might be another apt way to describe the bottom-up means for healing that sensorimotor psychotherapists, trauma-informed meditation teachers, and trauma therapists endorse.[53] All of these methods of healing traumatic memory and stabilizing the self begin with paying close attention to bodily experiences.

Repeated non-evaluative attention to the inner state of one's organism, the basic emphasis of secular and Buddhist mindfulness, develops a chaplain's vigilant attention to the subtle energies of her organic systems. This is to say, the social violence that Kleinman indicates takes a somatic form, which requires a somatic solution. Talk therapy does not suffice because forms of embodied distress require embodied psychotherapies and somatic modes of healing. The place to start more systematic change is the first step one takes toward listening to one's inner experience with more skill and teaching others to listen to their own inner experience with more skill. One way to improve care in medical systems entails slight, yet root level, shifts taking place in interpersonal situations enriched by mindfulness and other techniques of non-evaluative introspection. These ways of looking inward permit caregivers and patients to monitor and modify affective and cognitive experience. Systematic change may be necessary as well, but subtle changes can achieve great effects. Subtle changes will mean working in solidarity with patients, families, and other caregivers and could begin with the simple step of making space for more attuned care, interior to the self and between selves, in the clinical setting. They may begin with as small and simple a cue as a card on the door of a patient's room to indicate a transition from curative to end-of-life medical treatments.

In line with this granular vision of change, Freeman offered his experience designing a program that made a subtle practical adjustment at an Oregon hospital during the final years of his career. The program enabled greater attuned and empathic communication between caregivers, patients, and families by using signs that relayed messages to caregivers about a patient's code status. Freeman spoke of this program with a humble sense of pride after I had described Bartel's intervention at UVHS in a conversation with him. As part of an interdisciplinary committee for improving end-of-life care, Freeman and his colleagues met for a nearly an entire year in order to

---

[53] See Pat Ogden and Janina Fischer, *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment* (New York: Norton, 2015); David Emerson and Elizabeth Hopper, *Overcoming Trauma through Yoga: Reclaiming Your Body* (Berkeley: North Atlantic Books, 2011); David Trealeven, *Trauma-Sensitive Mindfulness: Practices for Safe and Transformative Healing* (New York: W. W. Norton and Co, 2018); Bessel Van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Penguin Books, 2014).

find a method for improving the staff visits for patients in the end stages of life. After meeting for two months, they agreed on only one small decision: "the picture and language for a small card that we would place at the door." The lavender card they designed together would inform clinical staff that the patient in the room was at the end of life. Placing this small card at the door served to remind any member of the caregiving team to enter the room in a gentler frame of mind. At the hospital, the lavender card became a signifier that prompted a distinct shift in bodily stance from one that expected to save a life to one that valued dying as a spiritually meaningful event.

The adjustment Freeman's interdisciplinary team made encouraged clinicians to be receptive to what they found in the rooms of the dying patients that they visited. Freeman said that the clinical team called this stage of care 'Code Calm.' In this cuing of the caregiving team to shift their mode of consciousness, the 'Code Calm' resembles the clinical pause. He elaborated on their caregiving routines for patients in this grieving stage: "We asked people to stop and take a breath when they saw the card. We asked them to rest into peacefulness. We told cleaning staff that they might encounter a dead body." The hospital advised all intensive care staff not to call in a code blue if they witnessed a dead body. While it took a few years for staff to stop reporting codes when the grief cards were displayed, eventually every staff person aligned with the hospital's new policy. From the intensive care unit, the hospital leadership applied the same simple change in every unit, which was still ongoing when Freeman retired a few years ago. The program used a small signal to orient a range of bodily, attitudinal, and processual shifts for caregivers that would improve the patient experience of death, including a form of pausing. Hospital leaders encouraged all staff to "stop and take a breath," Freeman said, in order to prepare to engage with death appropriately. 'Code Calm' exemplifies the kind of subtle change that draws attention to the inner experiences of patients and caregivers in interaction with each other.

In remarkably similar ways, clinical pausing and code calm evoke contemplative somatic modes of attention that reinvented traditions of American Zen cultivate in caregivers. Bartels, Moore, Freeman, and Cunningham have all engaged in small adjustments in embodiment and clinical routines that did not necessarily create novel institutions. These subtle, radical interventions deploy trainings from parallel institutions like UZC in medical systems to create an alternate space where caregivers can integrate new patterns of interpersonal caregiving. Through the adaptation of formal mindfulness practices, or informal and internalized mindfulness traits, caregivers are in the process of what Mol calls "doctoring" routines of spiritual caregiving and medical care more broadly. As a community of care, nurses, doctors, patients, and families are making small adjustments in fitting care to the needs of suffering patients. One can see in the work of spiritual caregivers the process of change in the practices of spiritual care, which for better or worse is becoming increasingly mindful. Will these new modes of embodiment and clinical routine reform the culture of medical care as Cunningham believes they will? Will making small

adjustments to spiritual caregiving practice, as a clinical chaplain's version of 'doctoring,' based on local logics of spiritual care significantly shift organizational logics in medical systems in the contemporary US?[54] What will emerge from this new orientation to caregiving inspired by socially engaged Buddhism and its art of contemplative caregiving instantiated in the pause? Whatever lasting shift 'The Pause' or 'Code Calm' might achieve, these subtle practices invite participation in compassionate care built on the solidarity between caregivers, patients, and families. In pausing and paying attention to the experiential meaning of bearing witness to death, Buddhist-inspired clinical caregivers are opening to the wisdom that mindful attention to death and suffering enables. They claim that this is the first step toward responding with compassion and resilience. Pausing constitutes a meaningful translation of mindfulness practice into the medical sphere, which in turn reshapes spiritual care.

Mindful Bodies in the Clinic: Altered Traits

Clinical chaplains are regularly crossing the boundaries between clinical and retreat settings, transmitting the bodily schema through which they mediate experiences and constitute their lived realities. In each setting, unique logics influence the practices that chaplains enact, yet across settings Zen chaplains embody integrated dispositions and character traits that allow them to navigate border crossings. Zen chaplains maintain that mindfulness meditation practices significantly alter these corporeal schema as altered traits, and a parallel neurobiological discourse that is in dialogue with Zen experiences of spiritual awakening has coalesced in the past three decades. In the section that follows, I explore how chaplains cultivate interpersonal attunement, equanimity, and meta-awareness across contexts: at home, in the clinic, or at the retreat center. They interlink each institution through the embodied minds and minded bodies that cross back and forth between these disparate contexts. The stories of Naomi Saks and Rob Adrian speak to how mindfulness practices dissolve the naturalized link that bundles together thoughts and feelings. Once Zen chaplains decouple experience and decenter from their own personal narratives, they enable themselves to more skillfully engage with their experience and the experience of others while holding stories loosely. After encountering patients with less top-down influence in perception, they can reincorporate vivid experiences with patients into narrative accounts of the their responsibilities as caregivers. The critical move chaplains are invited to make is to extend states of mental clarity associated with formal meditation practices across all experiential domains and contexts. This extension of mindful states into everyday life symbolizes and reinforces the transition from temporarily modified states to altered traits. As Goleman and Davidson say, "an altered

[54] Mol, *Logic of Care*, 108.

trait—a new characteristic that arises from a meditation practice—endures apart from meditation itself. Altered traits shape how we behave in our daily lives, not just during or immediately after we meditate."[55] Zen chaplains articulate their sense of responsibility for caregiving through the neurobiological discourse on altered traits, describing the linkages between meditation practices and compassionate caregiving in terms of their narratives of self-discovery and social action.

When chaplains cross over from practicing mindfulness in the retreat setting to the clinic, the shifts of action, emotion, sensation, and motivation that practices engender often hide in inconspicuous deeds that are at first unavailable to explicit awareness. They largely go unnoticed. For example, as UZC chaplain trainees bring practices to the clinic from the retreat center setting, they find tiny temporal margins in which to pause. They bring an open and non-evaluative awareness to experiences as mundane as walking between patient rooms. They stand back from sensations, thoughts, and emotions they routinely experience in order to sense into them more fully, monitor them, and consider them as patterns of internal energy that they can effectively modify through how they bring awareness to them. This is a ground-up form of healing attentiveness through the capacity of open awareness that encompasses and does not resist any of the human experience that it finds. It means translating mindfulness mediation techniques and traits of equanimity to the domestic scene. Tara Brach indicates how sensations play an essential role in this process. "In both Buddhist psychology and Western experiential therapy," she teaches, "this process of experiencing and accepting the changing stream of sensations is essential to the alchemy of transformation."[56] A Zen chaplain's spiritual awakening takes the form of establishing a new relationship of acceptance with her experience, especially its affective and perceptual dimensions. This view of the importance of mindfulness in reworking one's internal relationship to emotion and sensation reflects the current thinking of meditation teachers and contemplative neuroscientists.[57]

In this way of understanding bodily experience, emotions are the combination of elements of bodily sensation with patterns of thinking and storytelling. Current neuroscience theory reasons that these elements of experience continue to cause suffering until one feels them fully in their bodily location, consciously acknowledges them, and explicitly releases them. In this understanding, personal experiences are the building blocks of social orders which are "assembled through bodily practice" and "consciousness is embodied perception" of social relationships constituted by mental and emotional responses to primary sensations in the interactive social con-

---

[55] Goleman and Davidson, *Altered Traits*, 6.

[56] Brach, *Radical Acceptance*, Chapter 5.

[57] Goleman and Davidson, *Altered Traits*, 186.

texts of the world.[58] These corporeal schema of embodied perceptions are mapped by the interoceptive neural circuits that connect the insular cortex, dorsolateral prefrontal cortex, medial prefrontal cortex, thalamus, and distributed nervous system. Mindfulness practices thicken and strengthen the connections between the neural regions devoted to attention and neural regions devoted to processing the sensations and feelings of the body.[59] The altered character traits and modes of consciousness that mirror these changed neural networks emerge from the close collaboration of sentient tissues and the brain's interactive and flexible mapping of internal states. This type of sixth sense about internal experience is the most distinctive feature of American Zen Buddhist chaplaincy and mindful spiritual care. It means Zen Buddhist chaplains, and contemplative chaplains more generally, have heightened interoceptive awareness of the internal milieu and its affective flows as contributory to clinical chaplaincy encounters.

Consider the story palliative care chaplain Naomi Saks tells about how her meditation practices have evolved over the past two-and-a-half decades, leading her to have greater access to her embodied states as a source of information about others. Saks began meditating in 1995 after attending a meditation retreat at Spirit Rock. After her first encounters with meditation, she continued to practice for just over a decade before she attended Harvard Divinity School from 2007 to 2010. Once she graduated with her Master of Divinity, she entered into the profession of hospital chaplaincy. In the course of her spiritual life, she shifted away from actively focusing her attention on an anchor, and she started resting in a receptive, open monitoring state. Despite a slight change in her meditation method, she has maintained the daily practice of sitting for a least twenty or thirty minutes since she first began meditating. Rooted in West Coast Vipassana,[60] Saks calls this movement of "softening" herself to the moment and what happens in it "love." When she roots in her own bodily experience and softens to what she finds, Saks provides herself with the means by which to attune to the presence of the patients she serves. When she is present to herself, she can be present to others.

Her variation of contemplative practice has begun to move beyond any confineable location or formalized practice. This is because she has internalized the capacity to be more present even when she finds distress and hardship within or without to such a degree that it is intrinsic to her body-mind. "In my being," she continues, "I am present to what is arising moment by moment. I

---

[58] Martin Packer, *The Science of Qualitative Research* (New York: Cambridge University Press, 2011), 202. Packer contextualizes how ethnomethodology builds on the philosophical insights of phenomenologists Maurice Merleau-Ponty and and Martin Heidegger.

[59] Goleman and Davidson, *Altered Traits*, 179-184; Kieran Fox et al., "Review Article: Functional Neuroanatomy of Meditation: A Review and Meta-Analysis of 78 Functional Neuroimaging Investigations," *Neuroscience and Biobehavioral Reviews* 65 (2016): 220.

[60] Gleig, "Theravada to Tantra," 223.

can feel that person I am visiting in a hospital room in my body-mind in the moment I am there with them if I am attentive." Saks claims that when the patient's presence is available to her in her mind-body, she can better serve the patient because she can feel them. In her understanding of her practice, this awareness of the patients' experience in her sense of her own interior life is the index to point the patient toward "being and allowing their experience to happen." As Saks attunes to herself, she opens her awareness up to attune to others in her perception of the "inter-subjective field of being" as it displays itself in her interior space.[61] Exteroception—awareness of objects in the sensory fields of the five senses—and interoception—awareness of the internal bodily milieu—are intimately connected in her reflection on her experience.

Interpersonal resonances are a means, as Saks says, to understand how spiritual caregivers might invite patients to know and accept their experiences. Saks believes that early childhood relationships with primary caregivers make it difficult for many patients to access awareness of bodily states, sensations, and emotions that many in society associate with vulnerability and weakness. She proposes that our society makes experiencing emotions related to fear responses unpalatable and unmentionable in everyday conversation. What one cannot mention remains locked inside bodily experience and removed from explicit awareness, haunting the patient as a bodily shadow. The work of the spiritual caregiver is to free patients from these unvoiced bodily states by listening. "I am not teaching people I visit anything that is beyond them or new," she says, "but I am helping them find the truth. I am helping them find a way to come home." By finding a receptive caregiver, persons who are confronting the hardships of illness may have the ability to connect with themselves at a deeper level through the skilled attunement of a practiced listener. In Arthur Kleinman's language, together they may discover "the moral lesson that illness teaches."[62] By finding home again, the place of integration in their experience, patients have the opportunity to reframe the meaning of their illness.

Coming home in this sense, means finding a way in which to recover knowledge of one's own body. Illness invites a return to the body as the primordial location of human dwelling.[63] Serving another as a guide home also gives the servant-guide the reciprocal gift of knowing how to guide herself safely back home. "I am helping them, and I am helping myself to come home

---

[61] This phrase was repeatedly used by Fleet Maull from August 8, 2018 to August 11, 2018. It has conceptual resonances with approaches to embodiment based in phenomenology. See Francisco Varela, Evan Thompson and Eleanor Rosch, *The Embodied Mind: Cognitive Science and Human Experience* (Cambridge, Mass: MIT Press, 1991); Francisco Varela and Jonathan Shearer, "First Person Methodologies: What, Why and How?" *Journal of Consciousness Studies* 6 no. 2-3 (1999): 1-14; and Thomas Csordas, "Somatic Modes of Attention," *Cultural Anthropology* 8 no. 2 (1999): 135-156.

[62] Kleinman, *Illness Narratives*, 55.

[63] Thomas Tweed, *Crossing and Dwelling: A Theory of Religion* (Cambridge: Harvard University Press, 2006), 82.

and to soften when I am reactive and scared, when they are reactive and scared." In providing orientation to a patient looking for a route back to her dwelling in the body, the chaplain is gathering signs to orient her own homecoming. Spiritual care practices that find their bodily ground in mindfulness practices rely on the social and emotional resonance between and within human beings. This means that assisting in the repair of another's relationship with herself or the imprint of her experience in her body also heals the chaplain providing the assistance. Saks decided to return to clinical work in 2018 after a short stint as an administrator of a spiritual care department. She did so precisely because she values the reciprocal learning of clinical visits so highly. Her experience suggests that in doing mindfulness practice, the chaplain simultaneously improves her relationships with external actors—interpersonal attunement—and with herself internally—internal attunement.

The model for resilience proposed by Rushton, Kaszniak, and Halifax explains the ability to attune to others in affective, cognitive, and moral domains while drawing on memory that maintains personal differentiation as an outcome of emotional regulation (equanimity).[64] On the one hand, an equanimous spiritual caregiver finds creativity within her own array of memories and practices to approach varying social and institutional contexts with an empathic, loving, and compassionate mind that can take another person's point of view and feel their joys and pains without being engulfed by them. On the other hand, "if unconscious negative memory is overly activated, responses to the situation are more likely to be self-focused, causing empathic overarousal, vicarious or secondary stress, or personal distress."[65] Repeated occurrences of clinical moral distress leave a traumatic imprint in caregivers' bodies that may crescendo into feelings of avoidance, numbing, or judgment in the event that distressing events are not properly processed. To counteract this kind of clinical distress, many chaplains who attended trainings at UZC narrated incidents in which they incorporated Halifax's GRACE model or Tara Brach's RAIN model into clinical routines. For example, Rob Adrian adapted contemplative practices to his caregiving after he attended UZC's "Being with Dying" training in the summer of 2012. Adrian was working as a clinical chaplain for Piedmont Hospice in Charlottesville when I interviewed him. At the time he travelled to UZC, he had already completed board certification for clinical chaplaincy and dabbled in contemplative methods while working for a palliative care unit at a hospital in Dallas. Soon thereafter he began incorporating Brach's RAIN model while serving as a chaplain in a clinical unit, and he now offers trainings to other chaplains in the UVHS on contemplative methodologies in chaplaincy practice.

---

[64] Cynda H. Rushton, Alfred Kaszniak, and Joan Halifax, "Addressing Moral Distress: Application of a Framework to Palliative Care Practice," *Journal of Palliative Medicine* 16 no. 9 (2013): 1081, https://doi-org.proxy01.its.virginia.edu/10.1089/jpm.2013.0105.

[65] Ibid., 1083.

The impetus for Adrian's pivot toward the increased use of contemplative methods in caregiving practice emerged from the silence of UZC's Dokan-ji Zendo. He remarks, "I was not used to being in silence for such a long time." He said that even though he had spent nearly a decade developing his own contemplative practices before he went to train at UZC, the silence was bracing. Pointing back to his time learning with Halifax as a distinctive shift in his approach to chaplaincy, Adrian remarked, "Since then I have been integrating teachings from Upaya and from another teacher named Tara Brach, author of *True Refuge* and *Radical Acceptance*." Adrian then explained the steps of RAIN to me, which is an acronym that stands for Recognize, Allow, Investigate, and Nurture.[66] This approach to experience leads to self-acceptance and self-compassion. In a way similar to the GRACE model, RAIN combines the concentration practices of mindfulness with ethical enhancement practices like *metta* in order to promote decentering.[67] In line with phenomenological approaches to consciousness, RAIN and GRACE logically entail socially differentiated processes of mind by which chaplains discover their sense of self in relation to others who cohabit their local worlds. As Adrian remembers the teaching, "we figure out what is poking us, welcome it, ask what it wants, and remove ourselves from its encompassment. We end by not bathing in the emotion and thought that overpowers us." Adrian's take on the practice ends with taking more distance than Brach may advise (he removes himself from encompassment rather than nurturing what he finds), but he is nonetheless empowered to modify his experience through closely monitoring it. Practicing RAIN prevents the chaplain's awareness from being flooded by sensational, emotional, and narrative experiences during caregiving. GRACE and RAIN are two differentiated (but similar) models for contemplative practice that practitioners believe provide the means by which to achieve human flourishing.

When I asked Adrian how these practices come up in his daily routines as a chaplain, he responded that he intermittently finds himself accessing them in moments between encounters with others. Sometimes he realizes he needs to realign with his emotional state because his feeling of discomfort alerts him he is out of balance with himself. He practices while with colleagues at

---

[66] Tara Brach, "Meditation: The Practice of RAIN," accessed February 21, 2019, https://www.tarabrach.com; The episode notes say: "The acronym RAIN—Recognize, Allow, Investigate, Nurture—guides us in bringing mindfulness and compassion to difficult emotions. With practice, we can find our way home to open-hearted presence in the midst of whatever arises."

[67] For an explanation of decentering, see Daniel Goleman and Richard Davidson, *Altered Traits*, 196; Francisco Varela, Evan Thompson and Eleanor Rosch, *Embodied Mind*, lxiv; Anthony Lutz et al., "Investigating the Phenomenological Matrix," 640; Kirk Bingaman, "Incorporating Contemplative Neuroscience and Mindfulness-Based Therapies Into Pastoral Care and Counseling: A Critical Correlational Method." *Pastoral Psychology* 65 no. 6 (2016): 769-770; David Vago, "Mapping Modalities of Self-Awareness in Mindfulness Practice: A Potential Mechanism for Clarifying Habits of Mind," *Annals of the New York Academy of Sciences* 1307 no. 1 (2014): 38; and John Dunne, "Buddhist Styles of Mindfulness: A Heuristic Approach," in *Handbook of Mindfulness: Culture, Context, and Social Engagement* eds. Ronald Purser, David Forbes and Adam Burke (New York: Springer, 2015), 252.

work, in the car, or subsequent to difficult meetings. When he engages with colleagues, he discerns whether or not he can manage to attend to his emotions and feeling states as he feels them. He tries to welcome whatever affective content he finds. "If I can, I befriend it and watch it," he says of his emotional life, "It will move and change. If I push it away, it fights to get back in." He says that often in situations of long-term care and rehab, many patients and families struggle with deep sorrow and depression. Adrian's method for working with these groups of people is to offer them the opportunity to remain close to their experience, as scary as that proposition of intimacy with hardship might be for them. He prompts them to turn their awareness to what is close at hand, difficult experiences which human nature and social conditioning conjointly teach patients to avoid. Adrian urges patients, "Let's just sit and be with it." He often goes on to ask them simple questions that train their awareness on the bodily sensations they feel. He asks, "Where do you feel it in your body?" Dialoguing together, Adrian and the patient then point to where the sensations of pain, tension, or constriction appear. Next, patients describe what they sense or feel in their own words.

Asking patients to point to where they feel sensations in their body and then describe what they feel is a simple intervention. It rivals pausing in its simplicity and its power to alter clinical routines by teaching new modes of somatic awareness. Yet, American Zen's view on the noble truth of suffering is that it opens an experiential gateway to wisdom and insight. Bringing awareness to suffering is a means to finding meaning in illness largely lacking in the medical establishments of the late modern US. Late modern medicine is slow to view pain and suffering as anything but a problem to be eliminated, most often through pharmacological means. Skillfully responding to the grief, pain, and distress that he and other clinicians encounter in the clinical setting requires of Adrian that he make space in his conversations with patients to receive the emotional and sensate signs their bodies furnish them, which teaches patients how to attune to themselves. Careful attention to bodily states of grief or acute pain affords more nuanced knowledge of the body and its communicative practices, which Adrian has translated between the context of UZC retreats and his caregiving. He effects these translations amongst colleagues in clinical settings or while attending to himself as he drives in his car. Mindful spiritual care remakes medical contexts through the bodily schemas that chaplains bring into the medical context. The medicalization of mindfulness, dependent on print resources that imagine the mindful body and practices that make the body mindful, gives safe passage to American Zen modes of mind training into biomedical institutions because neuroscience studies of mindfulness make the necessary show of proof that the technique is based in evidence.

Adrian recently taught a session on mindfulness to the 2017 - 2018 cohort of clinical chaplains in residency under the supervision of his wife, Rebecca Adrian, at UVHS. One of the core practices that he has frequently incorporated in his teaching promotes the identification of recur-

rent narratives about the self that may inhibit empathic connection with patients and families. In this practice, the essential question that a chaplain asks herself is, "who am I right now?" This method of working with experience uses meta-awareness to disentangle the self from the potentially maladaptive mental schemas of the Default Mode Network (DMN) that frame narration in a negative valence outside of explicit thought.[68] When unopposed, the narratives of the DMN can turn back against the self and cause harm. Adrian urges chaplain residents to ask this question so that they might nimbly relax their habitual self-referencing when it proves maladaptive or harmful to themselves or the patients they visit.

Adrian calls this method working with "believed thoughts." He elaborated on the method: "I asked them to think about those kinds of questions for themselves regularly during the day." *Who am I? What am I seeking right now?* The practice of contesting believed thoughts that Adrian describes invites chaplains to engage in self-dialogue that will decouple their identity constructs, evaluative thinking, and self narrations. It will unbind chaplains from thoughts they believe to be true that might derail their ability to connect with and care for patients. Adrian continues, "We asked them to do this last time we met, to stop several times during the day and observe their thoughts without buying into them. We asked them to pay attention to their feelings and label their thoughts." Inventorying thought and feeling has served as a means to greater self-awareness in many forms of mindfulness practice. It is a form of self-examination that is shared between traditions. Labeling emotions and thoughts gives meditators the ability to gain critical distance from experience and see options for action, which is an essential element of response flexibility.

When mindful chaplains internally label experience, this action promotes metacognitive knowledge and skills.[69] Chaplains are thinking about their thinking, feeling, and acting in self-reflexive ways that provide the cognitive space in which to find flexible alternatives to caregiving challenges. They are questioning the beliefs and schemas that perpetuate forms of bias that prevent human beings from connecting with each other in a meaningful way. Such a process of gaining awareness of one's own patterns of thought and feeling gives chaplains greater flexibility to skillfully respond to encounters with patients. Adrian aims to provide the chaplains he has trained with better tools for finding what serves patient needs. He explains the value of pausing to engage in self-dialogue as a way for chaplains to gain control of themselves. I "get a handle on myself" by asking questions to make sure that I am not "led by my feelings" into dissonant care-

---

[68] Fadel Zeidan and David Vago, "Mindfulness Meditation-Based Pain Relief: A Mechanistic Account," *Annual New York Academy of Sciences* 1373 no. 1 (2016): 100. Zeidan and Vago write, "A large body of research on the resting state now supports the involvement of the DMN in a diverse array of cognitive processes that are associated with negative or maladaptive modes or states, such as rumination, craving, or distraction."

[69] Tomasz Jankowski and Paweł Holas, "Metacognitive Model of Mindfulness," *Consciousness and Cognition* 28 (2014): 64-80.

giving. The stories that clinicians tell, bound up with their sense of self—fragile yet resilient—and their clinical aims, have great power to constrain their options for action. In this DMN process of self-making, stories script the action options of the person who tells them, reinforcing a story-bound approach to living that can foreclose novel actions or self-descriptions. Over the past century, sociocultural analysis has invested great energy developing theoretical and empirical studies that show the power of narratives to shape self-concept, perception, and human experience.[70]

Adrian's training for hospital chaplains is inspired by his deep engagement with late modern American Zen Buddhist mindfulness practices. These practices have long valued bottom-up approaches to experience through an open state that monitors experience without judgment. The incorporation of American Zen approaches to experience in the clinical chaplaincy practices of a Protestant bears witness to the viability of this shift from top-down to bottom-up processing in the clinical caregiving world. This form of chaplaincy practice entails the moment-to-moment engagement with self-narration that holds up narrative elements to disinterested scrutiny as objects of reflection. Such functional decoupling of thoughts, feelings, narrative scripts, and evaluations gives mindful chaplains a measure of freedom to respond to patients in creative ways. When chaplains decenter, they provide themselves the necessary conditions for response flexibility and skillful use of the self in clinical interactions. It enables clinicians to disengage themselves from the maladaptive self-narration of the DMN. This is not to say that Adrian or other mindful chaplains are encouraging their peers to abandon narrative self-constitution altogether, for narratives have great value as means by which patients and clinicians make connections with each other. Rather mindful spiritual care calls for the skillful use of narrative ingredients, artfully blended, in the right composition for compassionate action. Mindful spiritual care teaches caregivers the means by which to monitor and modify narrative elements, consciousness, corporeal schema, and character traits in order to embody compassionate qualities of care.

---

[70] The literature on the part that narratives play in self-constitution is extensive and well integrated into anthropological and sociological theories and methods. A few of the perspectives that have contributed to my view are: Hannah Arendt, *The Human Condition* (Chicago: University of Chicago Press, 1958); Barbara Myeroff, *Number Our Days* (New York: Dutton, 1980); and Michael Jackson, *The Politics of Storytelling: Violence, Transgression, and Intersubjectivity* (Copenhagen Denmark: Museum Tusculanum Press, 2002). For critical accounts of narrative modes self-constitution, see Paul Atkinson, "Narrative Turn or Blind Alley?" *Qualitative Health Research* 7 no. 3 (1997): 325-344; Paul Atkinson and Sara Delamont "Rescuing Narrative from Qualitative Research," *Narrative Inquiry* 16 no. 1 (2006): 164–172; and Naomi Quinn "The Self," Anthropological Theory 6 no. 3 (2006): 362-384. See Arendt for the essential modern sociological statement on storytelling and self-constitution. Jackson elaborates on this this statement in a theoretical mode, whereas Myeroff applies it in a particularly thick description. Atkinson and Atkinson and Delamont systematically deconstruct narrative modes of self-making through evocative narrative. I find especially compelling Quinn's critique that urges anthropologists to pay greater attention to implicit body-mind structures in human experience and theories of personhood that frame and largely determine narrative elaboration.

Faithfulness and Weeping: Death at the Bedside of Janice Vekko

Friday afternoon's clinical routines beckoned me back onto the Baptist South Intensive Care Unit (ICU) after a short lunch and five minutes of mindfulness to begin my afternoon rounding on the units I serve as a chaplain resident. I cannot fully explain why, but my intuition said to start here in the afternoon, though before lunch I had intended to visit the Step-down ICU on the eighth floor. The eighth floor unit houses slightly less critical cases, but both units see their fair share of difficult and sometimes chronic or terminal medical problems. I walked to the nurses' station to check in with the unit clerk, and she pointed me to the first room across from the low countertop desks of the station. Janice Vekko was lying in the room attended on both sides by two women I had not yet met, though I had visited Vekko more than six times on both ICUs. The nurse assigned to the room busied herself with preparations outside, and then quickly went in. I had worked closely with Jen on several other critical cases, and she had a graceful patience that made her unflappable when she encountered angry criticism from patients or families. I walked over to the room.

Jen smiled at me, before saying, "I meant to call you earlier. She is dying and her friends are tending to her." She gestures toward the room, which has the curtain drawn.

"Who are her friends?" I asked, a bit nonplussed by their appearance but very glad that Janice would not be alone at the end.

"They are both nurses." (I learned later that both had cared for Janice in skilled nursing units and become close friends with her.) "The one with dyed hair is Sophia, and the other is Lydia. Sophia is a hospice nurse, and I believe that Lydia is also a nurse. They have been with her all morning."

I had noticed them during the tail end of interdisciplinary rounds. "I'm happy to see them with her," I say with a smile. Without delay, I entered the room. I felt a tinge of sorrow which bloomed from my belly into my chest. Janice was one of the first patients I had visited in the beginning of my residency who shared freely with me about her life. She requested I come visit her daily, which I never quite managed because of my busyness, but when I did visit we would talk about her career in finance or her volunteering with a youth group in the Catholic parish in which she grew up in Philadelphia. Janice was a staunch Catholic who armed her room with the remembering forms of not just one but two crucifixes. One was the small crucifix given to her as a young girl after her first communion. The other was nearly three feet tall and dominated the counter top right next to her trash can directly across from her. Janice positioned both crucifixes well to help her remember virtue. She had a generous heart and loved spending time with others.

Janice sat upright in the hospital bed that was set to a position that supported her back. Sitting upright reduced the discomfort of struggling to find her breath, which came in ragged, gurgling gasps. Inhales were quick and sharp, exhales extended and raspy. Lydia was at the right-hand side holding one of Janice's swollen hands, and Sophia at the left. Sophia sat in a chair and Lydia stood. They both looked on, transfixed by Janice's overweight, swollen, and bruised body. Her neck was black and green from a massive bruise that started at her collar bone and reached its fingers up toward her cheek. Her eyes were open but sunken, and her face twisted in such a way that her countenance resembled a Picasso painting, the Guernica of the hospital room. Gone was the vivid twinkle of Janice's eyes that had been present yesterday as she scribbled with a pen, "I'm dying," and I replied, "I know."

Lydia said, "Do you want to hold her hand." She was feeling overwhelmed with the suffering she witnessed. I kneeled on my left knee next to Janice so that I could be at her eye level, and I held her hand. I focused my attention on her face and how haggard it looked, and then I returned my attention to my breath. Long steady inhales, long steady exhales. I could feel my heart's steady beat in my chest. I looked back at Janice's face, and listened to her ragged breathing. I wondered for a second if the sound of her breath would haunt me. It had the quality that would normally elicit fear, and I wondered if I would fear the sound because it evoked the act of dying. I had heard the same way of breathing in other rooms where the medical team had removed the ventilation tube to allow someone to die in a natural way (allow natural death or AND is the way our system is talking about this way of dying now).

I realized that I was feeling fearful, explicitly named it as fear, and then I let the fear go. I returned my attention to my eyes as they perceived Janice struggling for air. I looked at her friend Sophia next to her and then to her friend Lydia. Lydia was crying with her head in Janice's lap. Sophia was urging her to be at peace. Over and again, Sophia talked to her like a midwife would coach a birthing mother.

"It's OK baby. You are OK. You can relax." In calming but firm tones, she would remind Janice that she didn't have to fight anymore to breathe. As Janice would sit up more in her bed, Sophia would argue with her a bit, "No baby, sit back, and let go!" And as Janice sat back, she would say, "Yes, there you go!" I both admired Sophia's faithfulness and reassuring words while I bristled at anyone trying to control someone's inborn reflexes to fight for breath. I held silent and breathed, noticing how I felt about these three women. Jen popped her head in to confirm that all was going well, bringing a box of tissues for Lydia, awash with tears, and Sophia, beginning to cry quietly. I felt sorrow in my heart for all of us.

Janice struggled to let go of her urge to breathe for thirty minutes while we stayed with her till the very end. Just a few minutes before she passed, Sophia turned to me and implored, "Will you pray for her?" My prayers had been my breaths and the noticing of my eyes and ears and

heart, but now I worded presence. And I prayed that God would welcome Janice into His arms and prepare a place for her at His right hand. And I prayed that she would dwell forever in a place with no death or tears, preparing a place for those of us who were her friends, so that one day we would all meet again. A few minutes later, Janice's heart rate dropped from thirty beats per minute to fifteen and then to zero. Her friends sighed deeply, and we looked at each other. We rested together for a moment in the sacred space that comes when someone we love leaves us and the world. And the words of the Death Cab for Cutie song rang in my ears, "Love is watching someone die. So who's gonna watch you die?"

We all set about tying up loose ends after about five minutes of sitting in silence. Sophia called Janice's estranged family, returning to the room outraged by how callous they were in receiving the news. Lydia and she then talked about liquidating Janice's belongings, since she had recently been evicted from her foreclosed upon house. Both women wanted to donate the goods to charity: they didn't want them going to waste. Jen talked with them about what arrangements were being made for handling Janice's remains. I stood with them and listened as they talked. We shared stories about how we first met Janice and what we found precious in her. Then we went about our days.

Coda: Embodying Everyday Practices at the End

Through their embodied traits, clinical caregivers introduce radical changes that are nearly unnoticeable at first. Bodies carry within them various logics of encountering, perceiving, experiencing, and constituting a world in various dimensions of time. The changes might be as small as learning to attend to one's breathing so as to notice one's emotions with more clarity and manage one's stress responses. Sociologist Courtney Bender rightly insists that embodied practices not only maintain social structures but also provide the means by which to alter them.[71] UZC currently trains chaplains who find themselves distributed across far-flung institutional contexts in healthcare, teaching these chaplains that their embodied everyday practice begins with mindful meditation as the master pattern for all other actions in the world. Mindfulness is the synecdoche for a ritualized Zen body, that becomes the focal asset of the Zen chaplain in the moral work of providing spiritual care. The clinical pause indexes this way of constituting spiritual presence in a simple gesture that requires no words. Its silence speaks of the rising influence of contemplative practices in mindful spiritual care. The pause is an everyday and ordinary practice: one simply takes a moment to breathe and relax into experience without choosing or acting. One

---

[71] Courtney Bender, *Heaven's Kitchen: Living Religion At God's Love We Deliver* (Chicago: University of Chicago Press, 2003), 6.

merely remains still and observes the body as the sensitive instrument of attuned perception. One merely accepts what one finds in the embodied mind and works with it.

This everyday self-acceptance is part and parcel of American Zen. It is so simple as to be hardly noticeable as a change agent in institutional life. Perhaps it does not go far enough for some, those who want to implement more dramatic reforms to the world. But these subtle practices do radically disrupt entrenched dehumanizing logics responsible for social violence. Pausing is recommended by its simplicity and everydayness. No matter the background ontological assumptions, religious traditions, or spiritual views of the participants, intensive meditation retreats entail continuous and repeated performance of simple actions like pausing, letting go, and returning to an awareness of the experience of the body. The repeated performance of these actions strengthens the mental capacities and thickens the neural circuits of the various regions of the neocortex, midbrain, and extended nervous system associated with interoception, intuition, attention, empathy, and compassion. The aggregate of repeated performances constitute American Zen contemplative practices, which alter the traits of meditators over time. UZC's clinical chaplaincy students are given the means by which to imagine these changes and the means by which to experience them. They learn neurobiological paradigms that map changes and meditative modes that drive them.

The effect of UZC permeates the institutional settings in which the chaplains that it trains pursue their professional lives through the changes in embodiment chaplains imagine and experience. These embodied changes are wrought by American Zen practices of paying close attention, letting go, pausing, bearing witness, and compassionate action. Historical study of meditation practices in the last two decades reveals that "mindfulness has managed to reach into nearly every institution of American society—churches, schools, hospitals, law enforcement, prisons, courts, military, media, pop culture."[72] The medicalization of mindfulness has provided the means by which chaplains trained at UZC have constituted mindful spiritual care. The primary means by which mindfulness has permeated the institutions of American society is through the bodies and reshaped nervous systems of late modern subjects who are seeking to transform themselves into, among other things, more compassionate clinicians. As the story from my clinical practice describes, I paused and attended to the sound of Janice Vekko's gurgling and rasping breath, and I wondered if this sound was terrifying or if one assumes that it is terrifying because it signifies death. I paused without explicitly thinking about pausing when the bodily schema and conditioned responses of my organism urged my consciousness to be patient and tender once I attended to my interior milieu. Soon after, I remembered Robert Aitken's *gatha* about con-

---

[72] Jeffrey Wilson, *Mindful America: The Mutual Transformation of Buddhist Meditation and American Culture* (Oxford: Oxford University Press, 2014), 6.

fronting death with equanimity and I did not weep, though Janice's close friends, nurses both, wept steadily with sorrow for their friend.

> Facing imminent death
> I vow with all beings
> to go with the natural process,
> At peace with whatever comes.[73]

If the late modern hospital is no place for dying and this is a problem with late modern medicine worth critiquing and changing, then embodying death and valuing its presence in a different way will necessarily come from practices that make room for the death, sorrow, and grief of others at peace with whatever comes. Mindful spiritual care can embody a form of power that rediscovers the value of living in the light of death and influences biomedical institutions to attend to death's wisdom. And new problems will arise.

---

[73] Robert Aitken, "The Dragon Who Never Sleeps," in *Engaged Buddhist Reader*, ed. Arnold Kotler (Berkeley: Parallax Press, 1996), 34; On how mindfulness reworks aversion behaviors, see Richard Davidson et al., "Alterations in Brain and Immune Function Produced by Mindfulness Meditation," *Psychosomatic Medicine* 65 (2003): 564-570; Davidson and his colleagues discuss how mindfulness meditation enables meditators to develop an "approach mindset" toward challenging events.

Conclusion

UZC, Mindful Spiritual Care, and the Case for Ethnography

Joan Halifax created an ecological framework for understanding the clinical chaplain's self that enabled her to lay the basis for the medicalization of mindfulness and the intensification of medicalization through dialogue with neurobiology. Her influence on the types of spiritual practices that clinical chaplains access in their moral practices of caregiving are visible throughout healthcare systems that have a connection with her or her clinical work. Halifax has had notable influence on chaplains with diverse faith commitments at the University of Virginia Health System (UVHS). Her current work draws on but reconfigures many of the formative interests of her youth, such as her curiosity about spiritual practices, shamanism and healing, rites of passage across cultures, and ethical practices of caregiving. As a young woman who came of age in the 1960s, she felt an attraction to the Civil Rights Movement and the counterculture, parlaying her exposure to discourses on Buddhist philosophy into a formal relationships with Zen teachers, most importantly Bernie Glassman. Halifax was an embodiment of liberal religion and seeker spirituality, both of which were undergirded in her experience, as in the experience of so many other spiritual seekers of her generation, by Romantic notions of the power of narrative self-expression. As with many other Zen converts during her era, Halifax's story valorizes her agency, uniqueness, wisdom, and compassion for marginalized persons. As she established her own Zen community at Upaya Institute and Zen Center (UZC), she laid down the foundations for an American Zen style of spiritual caregiving founded on a daily commitment to sitting meditation practice and the responsibility to care for vulnerable others.

Like with other forms of clinical chaplaincy training, UZC takes the base elements of grief, suffering, and loss and reworks them through self-expression, narrative accounts (case studies and personal reflections), dialoguing among a cohort of persons who identify, negotiate, and justify how and for whom they are responsible to care. As in the stories I recount, those of others and those of my own, mindfulness practice does not smooth over all the tensions, conflict points, or moral distress of the clinical worlds in which clinical chaplains work. Mindfulness practice does put an adaptive tool into the hands of a chaplain, a catalyst for "moral reorientation,"[1] and these caregivers tend to mythologize themselves as self-possessed heroes that humanize medicine and drink deep from the wisdom of grief. For the clinical chaplain caring for wounded persons, mindfulness gives her the means to gain greater awareness of herself in the moment, re-

[1] Cheryl Mattingly, *Moral Laboratories: Family Peril and the Struggle for a Good Life* (Berkeley: University of California Press, 2014), 84-89.

vealing patterns of avoidance with relation to past experiences with pain, loss, sorrow, anger, and grief. A chaplain, who grew up in a childhood marked by neglect, forgave his absent and addicted parents. Another chaplain, who overcame the loss of a son and a divorce, found resources within herself to commit herself to the vocation of spiritual care. Another chaplain, whose marriage crumbled, found in himself the space to let go of his judgmental stance toward himself and others. This work of spiritual maturity that blooms into increased compassion for self and others is slow going, painstaking, painful and may have occurred even without the application of mindfulness practices. Yet, without a doubt mindfulness practices were a part of the stories of healing through service to others recounted in this dissertation. It is invariably an energizing force in the stories, relationships, selves, and values presented to me. And mindfulness practices are methods of healing that find ample support in research designed to map the effects of contemplative practices on the neural structures of the brain and extended nervous system, even if its effects size is smaller than the studies show.

The particular examples of translation from retreat setting to medical scene that creative and mature mindful chaplains and nurses invent, reinvent the traditions of American Zen. They apply the teachings of the *dharma* to the medical scene, medicalizing the teachings of the Zen style of finding stability of mind through harmonization of the mind-body in the breath. Zen teachers, nurses, and chaplains pause to notice the meaningfulness of death, signal end-of-life processes with a lavender card, bear witness to the joys and pains of patient experience, wish others free of the suffering they witness them mired in, sit next to patients when they fall to the ground and curl up in a ball, and weep with patients or hold them when they break down in grief. Zen can become the background framework of bearing witness to what clients or patients do well or the means by which they thrive, as in the example of the Compassionate Care Initiatives (CCI) resource-based assessment. In many instances, teachers of Zen disciplines of spiritual care are not proposing that chaplains find something novel or new in their experience at all. In a theme established by Shunryu Suzuki, teachers of Zen spiritual care are really asking their students to begin again, to become beginners who are curious about experience, to rediscover the simplicity and strength of their own minds once anxiety and clinging fall away. This way of being has enough "softness" to work with anything it finds.[2] In the American Zen discourses that shape the mindfulness practices of chaplains trained at UZC, compassion will naturally arise once the conventional self falls away. After stripping away layers of the false self, the Zen chaplain will rediscover the presence of the extended self in her limitless hidden depths. Her referential compassion will eventually expand into non-referential compassion that knows no bounds. Yet, any form of compassion in clinical chaplaincy, including how, when, why, and for whom chaplains act with

[2] Shunryu Suzuki, *Zen Mind, Beginner's Mind: Informal Talks on Zen Meditation and Practice* (New York: Weatherhill, 2001), 115.

compassion to provide care will be identified, negotiated, justified, and analyzed by, in, and through interactive social practices that hold chaplains accountable for their responsibility to care. Joan Halifax may have felt compassion for the EMT whose wife had cancer come out of nowhere as she felt great pain, yet that compassion that came out of nowhere passed through her particular wounded body and served to draw her closer to a particular husband who faced the fear of losing an irreplaceably unique wife.

In my training cohort, each of us brings a unique story and set of skills to our clinical encounters with others, and the particular social conditions and identities each of us has formed over the course of our lives can be used as a means to empathic care. The chaplaincy training program is not a matter of individual transformation as one learns to dialogue with patients; it is a multi-party conversation within the community of caregivers, most intimately perhaps within the cohort with whom one trains and shares experiences. Each of the members of the cohort has experienced, holds faith in, and embodies a distinct and diverse artful form of interacting with patients and families, and my identity as a chaplain has necessarily changed as I have related to my cohort and reframed my sense of my/their/our values in caring for others.

The diversity of perspective, religious tradition, and orientation to perceptual, emotional, and cognitive experience in our cohort of six trainees is astounding even though we are almost all Protestant. One of my colleagues is a thirty-seven-year-old single white female evangelical who approaches experience through her emotions and grounds herself in scripture. She has survived multiple forms of emotional and sexual abuse and violence, and she has an immense heart for patients who struggle with perfectionism and the image of a punishing God, which she herself has struggled to overcome. Another of my colleagues is a fifty-six-year-old married white female who was ordained in the Unitarian Universalist Church and who grew up in poverty. She is a secular humanist who believes that all spiritual traditions have wisdom that provides useful guidance to persons of faith and conscience. She left rural Arkansas when she graduated high school and never looked back, and she serves our hospital system as a palliative care chaplain skilled in accompanying people at the end of life. Since leaving Arkansas, she has struggled with judging traditional or conservative views and is therefore immensely compassionate with others who face similar struggles, and is growing in her compassion for persons who embody conservative or traditional values.

Another of my colleagues is a fifty-five-year-old married black female who grounds herself in the Pentecostal faith and has an immense desire to embody the fruit of the spirit that Galatians names. She has experienced the trauma of racial prejudice in the schools she attended and the businesses where she has worked, overcome divorce and abuse of various kinds in her interpersonal relationships, and healed from the shame and judgment she felt when her son was imprisoned. She ministers to others out of her deep compassion for persons who feel similar shame or

feelings of unworthiness because of abuse or racial trauma. Another of my colleagues is a thirty-two-year-old married white male who moves between United Methodist and Cooperative Baptist churches. He lost a sister to disease when he was eight, and still feels anger and confusion over where God was in his time of isolation and fear as his family members distanced themselves from each other in their pain after his sister passed away, which is his motivation for bringing a message of hope to patients in the emergency department. Another of my colleagues is fifty-two-year-old white woman who is trained as a lawyer and is in the ordination process in the Episcopal Church. She has a pure and generous heart, and she provides spiritual care to others out of the resources of her lifelong commitment to social justice ministries of various kinds and her strong identity as a loving mother.

We learn about our values as caregivers in dialogical reflections on personal narratives. For instance, we recently discussed our pastoral theologies together in a group. I learned from each group member about myself in relation to them and about our community identity as a whole, but one particular encounter highlights how empathic resonance teaches me how to care for others who embody a different intersectional identity than my own. My black Pentecostal classmate wrote of her encounters with racism at a newly desegregated school in the 1970s. Our cohort had heard some of the story before, but my colleague's written words captured the power of an important gesture of friendship that a white classmate made to her. This courageous little white girl by the name of Michelle asked my colleague why she was crying and soothed her on the playground, and they became close friends. The memory of that time of friendship has made a lasting imprint on my colleague's values, and she has drawn on it as a resource to act with integrity when visiting white patients this residency year who confess to acts of racial prejudice in their past or who meet my colleague with prejudice in the clinical setting now. She is able to practice a ministry of presence in the midst of white people who are burdened with guilt or still actively engrossed with hate, and she is able to extend them forgiveness. Both of the times she told the story of her childhood, as she spoke about these memories, my heart ached for her, and I felt a sense of admiration for her courage in responding with integrity to continued systematic injustice. I admired her for providing "reliably responsible" compassionate care to everyone she meets in the hospital as best she can.[3] This is a lesson about courage for me that I feel deeply in my emotional experience because I care about my colleague, and I desire to provide compassionate care to all the persons I encounter in my own uniquely courageous way. It is not so much that I believe I can feel her pain as she feels it, the pain a resilient and successful black woman feels at the systematic injustices she has faced and still does. I do resonate with the pain she has felt from my own own emotional experiences that I feel in my body as a result of the neglect,

[3] Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (New York and London: Routledge, 1998), 115-120.

abuse, and social harm I have experienced. Her story inspires courage in me because she has responded to her own deep hurt with the practice of care, forgiveness, and kindness.

These brief sketches indicate the breadth of experience and orientation in a chaplaincy residency cohort, and suggest where my own Zen Methodist perspective aligns with or is differentiated from the other members of my primary moral community. The approach that UZC encourages chaplains to take, combining contemplative spiritual practices and the moral practice of providing compassionate care, has influenced my own personal style of chaplaincy. It has contributed to meaningful interfaith dialogue in clinical pastoral education programs like the one in which I am learning at Baptist Health, as contemplative methods continue to gain traction in medicalized spiritual care. Beyond my own experiences, my research shows a pattern of subtle adjustments of clinical routines, the "doctoring" of clinical caregiving practices on the part of chaplains, nurses, and physicians in order to humanize medicine. Ironically, neurobiological study that analyzes and maps inner experience in a thoroughly rationalized way, making the interior structures of subjective experience knowable and visible through rational discourse, has provided ideal grounds by which to revitalize the legitimacy of softer experiences like empathy, love, tenderness, attachment, and compassion. As clinical chaplains continue to support their practice through recourse to neuroscience discourse, they will further intensify the medicalization of their mindfulness practices. In many instances, the medicalization of practice will be so complete that any explicit mention of Zen content will be absent from instruction, lurking in the background.[4] This is the case in a recent teaching on a breathing technique (straw breathing) given by Fleet Maull that never mentions the *dharma* once, though Maull is an experienced *dharma* teacher endowed with the authority of Tibetan and Zen lineages. Maull touts the practice as a way to "self-regulate" and to disable "the scripts" of the past, which he says take the power of responsibility out of the hands of a disregulated and reactive person.[5] The practice of chaplaincy and the neurobiological study of meditation and spiritual values will continue to reciprocally inform each other in communities of Zen chaplains.

This particular hybridization of science and religious practice has proven a successful model that other religious communities—particular communities of Muslim, Jewish, or Christian contemplatives perhaps—will likely use to inform their own medicalization of spiritual practice. In-

---

[4] Candy Gunther Brown, "Can 'Secular' Mindfulness Be Separated from Religion?" in *Handbook of Mindfulness: Culture, Context, and Social Engagement* eds. Ronald Purser, David Forbes and Adam Burke (New York: Springer, 2016), 84-85. See especially her section on how secular mindfulness serves as a form of trojan horse to sneak religious values past the firewalls of secular institutions. Therefore, in my own phrasing and thinking about this process of secreting away encoded Buddhist philosophy in secularized mindfulness, "lurking" signals my residual distrust of the deceptiveness of this tactic.

[5] Fleet Maull,"Straw Breathing for Self-Regulation," April 18, 2019, https://www.youtube.com/watch?v=YCbAKwI4iEA.

deed the game is already afoot, as the work of Michael Spezio indicates, which Cynthia Bourgeault and other historians and teachers of centering prayer (Bourgeault is both) have noticed and written about in recent years.[6] Communities of Christian contemplatives, predominantly Roman Catholic and Eastern Orthodox but increasingly Protestants as well, engaged in chaplaincy work and other forms of pastoral ministries, will likely also medicalize the discourses that describe their practices, and therefore to some degree the practices themselves, as they seek to provide warrants that legitimize and justify their use of contemplative practices in hospitals and hospices. As neurobiology provides such powerfully descriptive means for mapping and visualizing the changes that contemplative practices unleash in the interior spaces of the body, it is likely to continue to attract medicalizing teachers of contemplative methods for self-discovery and community action. There are of course dangers in relying on neurobiology too much. And there is reason to believe that sustained engagement with the contemplative methods of the African diaspora will expand understandings of what it means for a practice to be contemplative well beyond the bias for silence and self-possession that dominates the literature, at least in English, on contemplative practices to date.[7] In theologian Barbara Holmes's estimation, comparisons of contemplative practices in the black church and African Diaspora with Eurocentric forms (including Indic forms seen as Aryan) will reveal that rather than silence "contemplation becomes an attentiveness of spirit that shifts the seeker from an ordinary reality to the *basiliea* of God."[8] As an ecumenical Christian and a supporter of the interfaith dialogue in which liberal voices in religious traditions engage, with a preference for inclusion of the trance and ecstatic participation of the spiritual practices of the African diaspora, I welcome these anticipated developments.

This particular dissertation contributes to the historical and ethnographic representation of Joan Halifax, UZC, and the integration of American Zen with self-expressive forms of seeker spirituality. With reference to the discourse of UZC, it shows how and why the ecological platform for selfhood that Halifax articulates primes her chaplaincy training for medicalization of mindfulness, which dialogue with neurobiology intensifies. It goes beyond analysis of discursive practices to an extended engagement with embodied spiritual practices and equally embodied

---

[6] Michael Spezio, "Forming Identities in Grace: Imitatio and Habitus as Contemporary Categories for the Science of Mindfulness and Virtue," *Ex Auditu* 32 (2016): 125-141; Michael Spezio, "Social Neuroscience and Theistic Evolution: Intersubjectivity, Love, and the Social Sphere," *Zygon* 48 no. 2 (June 2013): 428-438; Michael Spezio, Gregory Peterson and Robert Roberts, "Humility as Openness to Others: Interactive Humility in the Context of l'Arche," *Journal of Moral Education* (2018): 1-20; Cynthia Bourgeault, *The Heart of Centering Prayer: Nondual Christianity in Theory and Practice* (Boulder: Shambala, 2016), 110.

[7] Barbara Holmes, *Joy Unspeakable: Contemplative Practices of the Black Church* (Minneapolis: Fortress Press, 2017), 17-22.

[8] Ibid., 19.

moral practices in the context of retreat centers and medical institutions. As an ethnographic account of mindful spiritual care, this dissertation contributes to anthropological knowledge and practice related to contemplative practices, medical systems, and ethics. As a historical treatment of a particular style of clinical chaplaincy, it contributes to the historicization of clinical chaplaincy and its social and moral practices, which would appeal to pastoral theologians or scholars of religion. Chaplains of various traditions might read it to gain more knowledge about and insight into the history of our discipline or practical ways to incorporate mindfulness or neurobiology into clinical pastoral education, pastoral identify formation, or spiritual caregiving. Perhaps most intriguing to me at this stage in my career, my work has the potential to highlight how significantly small changes in medical routines could lead to radical differences in the quality of care. What I've written here could be of great use to administrators who are attempting to build more humane forms of medical institution. I give voice to this view even as the COVID-19 pandemic has led hospital administration throughout the city of Jacksonville, and our nation, to restrict patient visitation and isolate persons suspected of having contracted the virus. Sometimes moral distress has no obvious solution, but opening up nonjudgmental space to consider all the qualities of experience—perceptual, emotional, cognitive, energetic—and designing medical systems to incorporate this space in clinical routines and the skillful bodies of caregivers may be worth trying out.

My hopes for my own future research relate as much to the process of this project as to its content. Writing this dissertation and receiving the evaluative feedback of my readers and my peers has deepened my understanding of and skill with an ethnographic style of engagement, which I see as a critical means of coming to an understanding of hospital systems as I try to capture, reflect on, and dialogue about patient views about compassion in spiritual caregiving in medicine and medical care more broadly. Three recent studies by scholars of clinical nursing and palliative care describe this kind of care, and suggest why medical administrators would do well to pay more attention to qualitative studies about patient and family views on compassionate care that focus on patient experience as "compassionate collaborative care" (CCC), governed by "overarching values including empathy, sharing, respect, and partnership."[9] Scholars Kathryn Pfaff and Adelais Markaki argue for using CCC as a model to evaluate and orient healthcare to improve outcomes, strengthen healthcare provision, and control costs. Because delivering quality nursing care that patients view as empathic and compassionate is more cost effective and leads to better outcomes, it makes good business sense for a wide variety of stakeholders in medicine to learn about ethnography as a method and product for generating knowledge and organizing and refining social practices. As much as it is a hobby horse of critical anthropologists to ironically

[9] Kathryn Pfaff and Adelais Markaki, "Compassionate Collaborative Care: An Integrative Review of Quality Indicators In End-of-Life Care," *BMC Palliative Care* 16 (2017): 1 - 24.

refer to the deleterious effects of engineering corporate cultures,[10] it is nonetheless a legitimate way to construct one's moral practices of responsibility as a chaplain or caregiver: to use the practices of recognition embedded in ethnography (explicitly recognizing what we spiritual or medical caregivers might assume or take for granted by representing these things in ethnographic accounts) in order to become aware of and refine our caregiving practices. Along with Vincanne Adams and Sharon Kaufman, I believe that "ethnography can serve as both a social scientific method and a unique approach to medical practice," including spiritual caregiving in medicine.[11]

In two related studies Shane Sinclair and colleagues argue for an "empirically based clinical model of compassion" developed from semi-structured interviews of patients and families using a grounded theory method.[12] Based on their data, they argue for an understanding of compassionate care "as a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action."[13] Especially in palliative and end-of-life circumstances, they report that "studies have reported that patients and family members consistently identify components of compassion, such as receiving care that is "person-centered, responsive, and dialogic, as indicators of quality care."[14] Their qualitative study yielded the categories of "virtues," "relational space," "virtuous response," "seeking to understand," "relational communicating," "attending to needs," and "patient reported outcomes" of "alleviates suffering," "enhances wellbeing," and "enhances care."[15] Grounded in social practices of responsible and responsive interaction, the study initiates a style of qualitative research in nursing that my particular dissertation prepares me to engage more fully as an audience and collaborator.

One of the most important upshots of Sinclair and colleagues's study, which is rare in that it examines patient and family views, is that caregivers translate values into caregiving contexts from life outside medical institutions. The presence of embodied values like "love, kindness, acceptance" oriented styles of responding to patient needs with: 1) curiosity— "seeking to know the patient"—2) embodied communication—"demeanor"—3) behaviors—"listening and sup-

---

[10] Gideon Kunda, "Reflections on Becoming an Ethnographer," *Journal of Organizational Ethnography* 2 no. 1 (2013): 4-22, DOI 10.1108/JOE-12-2012-0061.

[11] Vincanne Adams and Sharon Kaufman, "Ethnography and the Making of Modern Health Professionals," *Culture, Medicine, and Psychiatry* 35 (2011): 313-320. DOI 10.1007/s11013-011-09216-0.318.

[12] Shane Sinclair et al., "Compassion In Health Care: An Empirical Model," *Journal of Pain and Symptom Management* 51 no. 2 (2016b): 193.

[13] Ibid., also 195.

[14] Ibid., 194.

[15] Ibid., 197.

portive words"—and 4) engagement—"dialogue."[16] These styles of interaction in turn led to patient reports of the alleviation of suffering, enhancement of wellbeing, and enhancement of care. This patient-centered approach to research grew out of the scoping review of the healthcare literature completed by the same research group that analyzed 648 studies to identify trends and conclusions in the literature about compassion in healthcare. Through qualitative engagement with the literature on compassion, the research group realized an aporia (patient and family views on compassion) that further study could fill to the benefit of health systems, caregivers, patients, and families. They offer this summary of the study that they conducted to begin to fill this gap in knowledge: "compassion was an outcome and a process of intuition and communication grounded in emotional resonance and a response to suffering predicated on several distinct virtue-based motivators."[17] They found that seven dimensions of interpersonal value (virtues in their language) were linked with compassion: "attentiveness, listening, confronting, involvement, helping, presence, and understanding."[18] The views expressed in Sinclair and colleagues's summary of their research on compassion see compassionate caregiver actions as the outcome of healthcare provider attentiveness to patient desires for care, dialogue with patients and families about care, willingness to be present to patient pain and suffering, and desire to alter care to suit patient wants and needs.

As a chaplain and ethnographer, I would like nothing better than to participate in the generation of such kinds of knowledge about patient views on compassion in order to improve the practice of spiritual care in medicine and medical care in its curative and end-of-life forms no matter where these arts and sciences of care are practiced. Is this desire an expression of my attraction to Zen heroism and/or is it a form of altruism that serves legitimate needs of medical systems?

***

It had been a slow on-call shift on Easter, after COVID-19 had disrupted the hospital routines established during the first seven months of my CPE residency. The pandemic had thrown the hospital system into chaos, with ripples of anxiety felt in each unit in different ways. Generally, nurses and other members of the caregiving team were feeling uncertainty about the future, annoyance with more rigorous hygiene procedures (already quite strict in normal circumstances), and worries about money because of reduced hours. Each unit had emptied of its usual volume of

---

[16] Ibid.

[17] Shane Sinclair et al., "Compassion: A Scoping Review of the Healthcare Literature." *BMC Palliative Care* 15 (2016a): 4.

[18] Ibid.

patients, which the administration had intentionally done to prepare for the surge of patients that COVID-19 was predicted to cause. The surge had not happened yet, and the hospital staff were waiting in anticipation for the viral tsunami to hit, scanning the digital ocean for signs of the approaching wave. I sat in the spiritual care office on the seventh floor of Baptist South talking on my cellphone to Sam Chinn, who has supervised me this year. We used FaceTime as I walked toward and looked out of the window in the hallway that looks north over the wooded precincts of South Jacksonville between Baptist South and the Mayo Clinic a few miles to the north.

Over the past seven months, Sam's warmth and honesty had earned my trust. I was more willing to give heed to his insights into my character because I knew that he felt and understood the persistent struggles I face as a single dad trying to support three daughters on the income of a graduate student and chaplain resident, both of which make less money than a first-year teacher. Of course, despite considerable financial assistance from my parents and ex-wife, this left me in a persistent state of anxiety over money matters.

Sam asked me about a recent visit I had mentioned in the last week of our written reflections, which COVID-19 had disrupted, at least in my case, causing me to cease writing weekly reflections altogether. "What was it about the visit you wanted to talk about, I am forgetting the exact details since you reported on it three weeks ago?" The director of spiritual care has diverted Sam from attending primarily to the education of chaplain residents because of the increased needs of the department for digital connectivity. Sam has really started learning a whole new position in addition to his work as our educator.

"I visited a patient on the ICU that sticks out in my memory. Let me tell you about him. He had been on the step-down ICU, and I had seen him a few times up there." The step-down ICU is on the eighth floor, at the very top of the hospital. The man was a working class, white Protestant who looked much older than his fifty seven years. "A nursing manager mentioned that he had bipolar disorder, and I visited him and felt like we had good rapport. He was transferred down to the ICU the week before Baptist changed the visitation protocols because of COVID-19. The Friday before visitation policies changed, I went to see him for the fourth or fifth time.

"Since I had visited him before, I expected him to share a little about his life and want me to pray with him. I walked into the room, and he was listening to Metallica with his headphones on. As we started to talk, he took the headphones off and started to say that he himself had been in a rock band. At first he started to say he was in Black Sabbath, and he started directing me to look on my phone for him in photos of the band. Then, he started saying he was in a Christian metal band local to Jacksonville, and he had me look online for photos of him in this band. I was looking for photos of him as he kept insinuating that he was in a band for like ten minutes, and I became rather confused about what I was doing. I didn't like feeling confused. I can't say that I wasn't influenced by the pandemic too.

"I said to him, 'I am really feeling quite confused about what you want from me right now.' I was trying to use my countertransference to talk with him about what was going on between us in a direct way. I did not say that I was feeling frustrated, but his voice and tone then became frustrated." I had felt a rising energy like tingling from upper chest to throat, like internal pop rocks, before I spoke. "He kept hinting that I should get where he was coming from, but I really didn't understand at the moment, and really could only locate that we were both frustrated, and I was confused. After that, he lost interest and dismissed me, and I left and told him I would return the next time I was in the hospital. The next time I had a shift I did return, but he was no longer verbal. He died just a few days later, and his family had to visit him one at a time for five minutes." These were the new visitation protocols in place to prevent the spread of the virus.

Sam asked, "Knowing yourself, what would you say was going on between you?"

"Well at the very least, I know I didn't like feeling confused. I could sense that both of us were frustrated, and maybe I could have worked with that differently."

"You saw his helplessness and you felt that sense of helplessness too in your confusion. Knowing how much you like feeling competent, what would say about your relationship to him in this moment? Could it be your frustration mirrored his frustrated helplessness?"

"Yes, and now I feel guilty, you know? I could have come closer to how he was feeling and given him better care in the end."

"You are only human and a lot was going on." Sam said reassuringly to normalize my feelings of responsibility. "Sure, you could have done something different. What would you have done differently? What are unique gifts that you have in meeting this particular patient's needs?"

I sat for a long time as I listened to the silence on the phone and deepened my introspection. "I have a firm grip on my own sorrow and my anger, and I could have used these feelings to join with him and talk about what I felt come up between us."

Sam's rejoinder, "Yeah, that's true. It isn't what I was thinking. I was thinking that, as you've said before, because you tend to hover over your relationships with others without feeling carried away by emotions, this gives you an ability to be playful and joke with him about how you might be feeling."

A sudden flash of insight comes to me and I'm a little excited to share, "One other time, he did something similar to me by insinuating I should know something I didn't, and I just went with it and played along while I kept smiling. It worked the first time, and I could have done something similar or waited out the feeling of confusion."

"Right, you had options." So the dialogue about how I can be a moral agent responsible for spiritual care ensues, contextualized in my spiritual caregiving by Christian and Zen contemplative practices. It is our work as caregivers to articulate what we find of value in order to narratively orient and reorient our moral processes of becoming so that together we can care.

Bibliography

Adams, Vincanne and Sharon Kaufman. "Ethnography and the Making of Modern Health Professionals." *Culture, Medicine, and Psychiatry* 35 (2011): 313-320. DOI 10.1007/s11013-011-09216-0.318.

Aitken, Robert. "Forward." In *On Zen Practice: Body, Breath, and Mind*, edited by Taizan Maezumi and Bernard Glassman, xvii-xix. Boston: Wisdom Publications, 2002.

Aitken, Robert. "The Dragon Who Never Sleeps." In *Engaged Buddhist Reader*, edited by Arnold Kotler, 27-37. Berkeley: Parallax Press, 1996.

Arendt, Hannah. *The Human Condition.* Chicago: University of Chicago Press, 1958.

Atkinson, Paul. "Narrative Turn or Blind Alley?" *Qualitative Health Research* 7 no. 3 (1997): 325-344.

Atkinson, Paul and Sara Delamont. "Rescuing Narrative from Qualitative Research." *Narrative Inquiry* 16 no. 1 (2006): 164–172.

Austin, James. *Zen Brain Horizons: Toward a Living Zen.* Cambridge: MIT Press, 2016.

Austin, James. *Zen-Brain Reflections.* Cambridge: MIT Press, 2006.

Bartels, Jonathan. "The Pause." Accessed January 7, 2017. https://vimeo.com/143628865.

Bauer-Wu, Susan and Dorrine Fontaine. "Prioritizing Clinician Wellbeing: The University of Virginia's Compassionate Care Initiative." *Global Advances in Health and Medicine* 4 no. 5 (2015): 16-22.

Behar, Ruth. *The Vulnerable Observer: Anthropology That Breaks Your Heart.* Boston: Beacon Press, 1996.

Bell, Catherine. *Ritual Theory, Ritual Practice.* Oxford, New York: Oxford University Press, 1992.

Bender, Courtney. *The New Metaphysicals: Spirituality and the American Religious Imagination.* Chicago: University of Chicago Press, 2010.

Bender, Courtney. *Heaven's Kitchen: Living Religion at God's Love We Deliver.* Chicago: University of Chicago Press, 2003.

Bender, Courtney, and Pamela E. Klassen, eds. *After Pluralism: Reimagining Religious Engagement*. New York: Columbia University Press, 2010.

Benson, Herbert. *The Relaxation Response.* New York: William Morrow Paperbacks, 1975.

Bingaman, Kirk. "Incorporating Contemplative Neuroscience and Mindfulness-Based Therapies Into Pastoral Care and Counseling: A Critical Correlational Method." *Pastoral Psychology* 65 no. 6 (2016): 759-772.

Bingaman, Kirk. "When Acceptance Is the Road to Growth and Healing: Incorporating the Third Wave of Cognitive Therapies Into Pastoral Care and Counseling." *Pastoral Psychology* 64 no. 5 (2015): 567-579.

Bochner, Art. "Narrative's Virtues." *Qualitative Inquiry* 7 no. 2 (2001): 131-158.

Bochner, Art and Carolyn Ellis. *Evocative Autoethnography: Writing Lives and Telling Stories.* Walnut Creek: Left Coast Press, 2016.

Bodian, Stephen. *Beyond Mindfulness: the Direct Approach to Lasting Peace, Happiness, and Love.* Oakland: Non-duality Press, 2017.

Bourdieu, Pierre. *Outline of a Theory of Practice*. Translated by Richard Nice. Cambridge: Cambridge University Press, 1977.

Cynthia Bourgeault, *The Heart of Centering Prayer: Nondual Christianity in Theory and Practice.* Boulder: Shambala, 2016.

Brach, Tara. "Meditation: the Practice of RAIN." Accessed February 21, 2019. https://www.-tarabrach.com.

Brach, Tara. *Radical Acceptance: Embracing Your Life with the Heart of a Buddha.* New York: Bantam Books, 2004.

Braude, Anne. *Radical Spirits: Spiritualism and Women's Rights In Nineteenth-Century America.* Boston: Beacon Press, 1989.

Braun, Erik. "Mindful but Not Religious: Meditation and Enchantment in the Work of Jon Kabat-Zinn." In *Meditation, Buddhism, and Science*, edited by David McMahan and Erik Braun, 173-197. Oxford: University of Oxford Press, 2017.

Braun, Erik. *The Birth of Insight: Meditation, Modern Buddhism, and the Burmese Monk Ledi Sayadaw*. Chicago: The University of Chicago Press, 2013.

Brown, Candy. "Can 'Secular' Mindfulness Be Separated from Religion?" In *Handbook of Mindfulness: Culture, Context, and Social Engagement*, edited by Ronald Purser, David Forbes and Adam Burke, 75-94. New York: Springer, 2016.

Byock, Ira. "Introduction." In *Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death.* Boston: Shambala, 2008. Audible.

Byock, Ira. "Imagining People Well." In *Awake at the Bedside: Contemplative Teachings on Palliative and End-of-Life Care*, edited by Koshin Paley Ellison and Matt Weingast, 281–297. Somerville: Wisdom Publications, 2016.

Byrnes, Joshin. "The Embrace of the Boddhisattva." Recorded January 19, 2019. https://www.upaya.org/2019/02/byrnes-embrace-bodhisattva/.

Cadge, Wendy. *Paging God: Religion In the Halls of Medicine.* Chicago: University of Chicago Press, 2012.

Chapple, Helen Stanton. *No Place for Dying: Hospitals and the Ideology of Rescue.* Walnut Creek: Left Coast Press, 2010.

Chödrön, Pema. *The Places that Scare You: A Guide to Fearlessness in Difficult Times.* Boulder: Shambala, 2017. Audible.

Cohen, Stanley. *Visions of Social Control*. Cambridge: Polity Press, 1985.

Craig, A. D. "Interoception: the Sense of the Physiological Condition of the Body." *Current Opinion in Neurobiology* 13 (2003): 500-505.

Critchley, Hugo et al. "Neural Systems Supporting Interoceptive Awareness." *Nature Neuroscience* 7 no. 2 (2004): 189-195.

Csordas, Thomas. "Somatic Modes of Attention." *Cultural Anthropology* 8 no. 2 (1993): 135-156.

Dalai Lama. "Cultivating Altruism." In *The Engaged Buddhist Reader*, edited by Arnold Kotler, 3-9. Berkeley: Parallax Press, 1996.

Damasio, Antonio. *The Strange Order of Things: Life, Feeling, and the Making of Cultures.* New York: Penguin Random House, 2018. Audible.

Damasio, Antonio. *Self Comes to Mind: Constructing the Conscious Brain.* New York: Pantheon Books, 2010. Audible.

Damasio, Antonio. "Feelings of Emotion and the Self." *Annual New York Academy of Sciences* 1001 (2003): 253-261.

Davidson, Richard et al. "Alternations in Brain and Immune Function Produced by Mindfulness Meditation." *Psychosomatic Medicine* 65 (2003): 564-570.

De Michelis, Elizabeth. *A History of Modern Yoga: Patanjali and Western Esotericism.* New York: Bloomsbury Academic, 2005.

Diangelo, Robin. *White Fragility: Why It's So Hard for White People to Talk about Racism.* Boston: Beacon Press, 2018.

Drucker, Malka and Gay Block. *White Fire: A Portrait of Women Spiritual Leaders In America.* Woodstock, Vt: SkyLight Paths Pub, 2003.

Durkheim, Emile. *Moral Education: A Study In the Theory and Application of the Sociology of Education.* Translated by Everett K. Wilson and Herman Schnurer. New York: Free Press, 1961.

Dunne, John. "Buddhist Styles of Mindfulness: A Heuristic Approach." In *Handbook of Mindfulness: Culture, Context, and Social Engagement*, edited by Ronald Purser, David Forbes and Adam Burke, 251-270. New York: Springer, 2016.

Dykstra, Robert, ed. *Images of Pastoral Care: Classic Readings.* St. Louis: Chalice Press, 2005.

Ellison, Koshin Paley and Matt Weingast, eds. *Awake at the Bedside: Contemplative Teachings on Palliative and End-of-Life Care.* Boston: Wisdom Publications, 2016.

Emerson, David and Elizabeth Hopper. *Overcoming Trauma through Yoga: Reclaiming Your Body.* Berkeley: North Atlantic Books, 2011.

Erik Erikson, *Insight And Responsibility: Lectures On The Ethical Implications Of Psychoanalytic Insight.* New York: W. W. Norton and Co., 1964.

Farias, Miguel and Catherine Wikholm. "Has the Science of Mindfulness Lost Its Mind?" *BJPsych Bulletin* 40 no. 6 (2016): 329-332. doi:10.1192/pb.bp.116.053686.

Fox, Kieran et al. "Review Article: Functional Neuroanatomy of Meditation: A Review and Meta-Analysis of 78 Functional Neuroimaging Investigations." *Neuroscience and Biobehavioral Reviews* 65 (2016): 208-228.

Frank, Arthur W. *Letting Stories Breathe: A Socio-Narratology.* Chicago: University of Chicago Press, 2010.

Frank, Arthur. *The Wounded Storyteller: Body, Illness, and Ethics.* Chicago: University of Chicago Press, 1995.

Gerkin, Charles. *An Introduction to Pastoral Care.* Nashville: Abingdon Press, 1997.

Gerkin, Charles. *The Living Human Document: Re-Visioning Pastoral Counseling in a Hermeneutical Mode.* Nashville: Abingdon Press, 1984.

Gerth, Hans Henreich and C. Wright Mills. "Introduction: The Man and His Work." In *From Max Weber: Essays In Sociology*, edited by H. H. Gerth and C. Wright Mills, 3-74. Milton Park, Abingdon, Oxon, New York: Routledge, 2009. Ebook Central - Academic Complete.

Gethin, Rupert. "On Some Definitions of Mindfulness." *Contemporary Buddhism* 12 no. 1 (2011): 263-279.

Giles, Cheryl A. and Willa B. Miller, eds. *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work.* Boston: Wisdom Publications, 2012.

Glassman, Bernard. *Bearing Witness: A Zen Master's Lessons in Making Peace.* New York: Bell Tower Press, 1998.

Gleig, Ann. "From Theravada to Tantra: The Making of an American Tantric Buddhism?" *Contemporary Buddhism* 14 no. 2 (2013): 221-238.

Goldstein, Joseph. "Meditation Practice: A Practice of Dying." In *Awake by the Bedside: Contemplative Teachings on Palliative and End-of-Life Care*, edited by Koshin Paley Ellison and Matt Weingast, 101-103. Somerville: Wisdom Publications, 2016.

Goleman, Daniel and Richard Davidson. *Altered Traits: Science Reveals How Meditation Changes Your Mind, Brain, and Body.* New York: Penguin, 2018.

Goyal, Madhav et al. "Meditation Programs for Psychological Stress and Wellbeing: A Systematic Review and Meta-analysis." *JAMA Internal Medicine.* 174 no. 3 (2014): 357-368.

Halifax, Joan. *Standing at the Edge: Finding Freedom Where Fear and Courage Meet.* New York: Flitiron Books, 2018.

Halifax, Joan. "Compassion as the Radicalism of Our Time." Accessed February 28, 2018. http://www.wisdom2summit.com/Videos/myriad_single_element/1798.

Halifax, Joan. *Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death.* Boston: Shambala, 2008. Audible.

Halifax, Joan. "Being with Dying: Contemplative Care of Dying People." Unpublished talk transcribed by Shelly Haley given at the University of Virginia Medical Center on October 21, 1998. https://www.upaya.org/dox/Being_Dying.pdf.

Halifax, Joan. *The Fruitful Darkness: A Journey Through Buddhist and Tribal Wisdom.* New York: Grove Press, 1993.

Halifax, Joan. *Shamanic Voices: A Survey of Visionary Narratives*. New York: E. P. Dutton, 1979.

Hall, David D., ed. *Lived Religion In America: Toward a History of Practice.* Princeton: Princeton University Press, 1997.

Hanks, William. *Language and Communicative Practices.* Boulder: Westview Press, 1996.

Hanson, Rick. *The Enlightened Brain: The Neuroscience of Awakening.* Boulder: Sounds True, 2014. Audible.

Hedstrom, Matthew. *The Rise of Liberal Religion: Book Culture and American Spirituality In the Twentieth Century*. Oxford, New York: Oxford University Press, 2013.

Herman, Judith. *Trauma and Recovery* revised ed. New York: Basic Books, 1997.

Hickey, Wakoh Shannon. "Meditation Is Not Enough." In *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*, edited by Cheryl A. Giles and Willa B. Miller, 17-26. Boston: Wisdom Publications, 2012.

Hobsbawm, Eric."Introduction: Inventing Traditions." In *The Invention of Tradition*, edited by Eric Hobsbawm and Terrence Ranger, 1-14. Cambridge: Cambridge University Press, 2016.

Holifield, E. Brooks. *A History of Pastoral Care in America.* Nashville: Abingdon, 1983.

Holmes, Barbara. *Joy Unspeakable: Contemplative Practices of the Black Church.* Minneapolis: Fortress Press, 2017.

Hulse, Dory. "U.Va. Schools of Nursing and Medicine Building a Transformational Model for Compassionate Care Worldwide." Accessed December 12, 2019. https://news.virginia.edu/content/uva-schools-nursing-and-medicine-building-transformational-model-compassionate-care.

Jackson, Michael. *The Politics of Storytelling: Violence, Transgression, and Intersubjectivity.* Copenhagen Denmark: Museum Tusculanum Press, 2002.

Jackson, Michael. "Knowledge of the Body." *Man* 18 no. 2 (1983): 327-345.

Jankowski, Tomasz and Paweł Holas. "Metacognitive Model of Mindfulness." *Consciousness and Cognition* 28 (2014): 64-80.

Joas, Hans. *The Genesis of Values*. Chicago: University of Chicago Press, 2000.

Kabat-Zinn, Jon. *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness.* New York: Bantam Books, 2013.

Kaufman, Sharon. *—and a Time to Die: How American Hospitals Shape the End of Life.* New York: Scribner, 2005.

Keating, Thomas. *Invitation to Love: The Way of Christian Contemplation.* London: Bloomsbury, 2012.

Klassen, Pamela E. *Spirits of Protestantism: Medicine, Healing, and Liberal Christianity.* Berkeley: University of California Press, 2011.

Kleinman, Arthur. "Caregiving: The Odyssey of Becoming More Human." *The Lancet* 373 no. 9660 (2009): 292–294.

Kleinman, Arthur. "Catastrophe and Caregiving: The Failure of Medicine as an Art." *The Lancet* 371 no. 9606 (2008): 22-23.

Kleinman, Arthur. *What Really Matters?: Living a Moral Life Amidst Uncertainty and Danger.* New York: Oxford University Press, 2006.

Kleinman, Arthur. "The Violences of Everyday Life: the Multiple Forms and Dynamics of Social Violence." In *Violence and Subjectivity*, edited by Veena Das, 226-241. Berkeley: University of California Press, 2000.

Kleinman, Arthur. *The Illness Narratives: Suffering, Healing, and the Human Condition.* New York: Basic Books, 1988.

Kleinman, Arthur and Kleist Van Der Geest. "'Care' In Health Care: Remaking the Moral World of Medicine." *Medische Antropologie* 21 no. 1 (2009): 159-168.

Klimecki, Olga M. et al. 2014. "Differential Pattern of Functional Brain Plasticity After Compassion and Empathy Training." *Social Cognitive and Affective Neuroscience* 9 no. 6 (2014): 873–879. https://doi.org/10.1093/scan/nst060.

Klumpers, Floris et al. "How Human Amygdala and Bed Nucleus of the Stria Terminalis May Drive Distinct Defensive Responses." *The Journal of Neuroscience* 37 no. 40 (2017): 9645-9656.

Kotler, Arnold, ed. *Engaged Buddhist Reader.* Berkeley: Parallax Press, 1996.

Kübler-Ross, Elisabeth. *On Death & Dying: What the Dying Have to Teach Doctors, Nurses, Clergy & Their Own Families.* New York: Scribner, 1969.

Kueter, Christine Phelan. "Mar. 13: Upaya Founder Joan Halifax to Speak." UVA School of Nursing, January 10, 2019. https://www.nursing.virginia.edu/news/roshi-joan/.

Kunda, Gideon. "Reflections on Becoming an Ethnographer." *Journal of Organizational Ethnography* 2 no. 1 (2013): 4-22. DOI 10.1108/JOE-12-2012-0061.

Lambek, Michael. *The Ethical Condition: Essays On Action, Person, and Value.* Chicago: University of Chicago Press, 2015.

Lazar, Sara. "The Neurobiology of Mindfulness." *Mindfulness and Psychotherapy* 2nd Edition, edited by Christopher Germer, Ronald Siegel, and Paul Fulton, 282-294. New York: The Guilford Press, 2013.

LeDoux, Joseph. *Synaptic Self: How Our Brains Become Who We Are.* New York: Viking, 2002.

Levine, Peter. *Healing Trauma: A Pioneering Program for Restoring the Wisdom of Your Body.* Boulder: Sounds True, 2008.

Levy, Robert and Douglas Hollan. 2015. "Person-Centered Interviewing and Observation." In *Handbook of Methods in Cultural Anthropology* 2nd Edition, edited by Bernard Russel, 313-342. Lanham: Rowman & Littlefield Publishing Group.

Lim, Julian et al. 2018. "Dynamic Functional Connectivity Markers of Objective Trait Mindfulness." *NeuroImage* 176: 193-202. https://doi.org/10.1016/j.neuroimage.2018.04.056.

Lindhal, Jared et al. "The Varieties of Contemplative Experience: A Mixed-Methods Study of Meditation-Related Challenges in Western Buddhists." *Plos One* 12 no. 5 (2017): 1-38.

Long, Charles. *Significations: Signs, Symbols and Images in the Interpretation of Religion.* London: Davies Group Publishers, 1999.

Lopez Jr., Donald. *Buddhism and Science: A Guide for the Perplexed.* Chicago: Chicago University Press, 2008.

Lutz, Antoine et al. "Investigating the Phenomenological Matrix of Mindfulness-Related Practices from a Neurocognitive Perspective." *American Psychologist* 70 no. 7 (2015): 632-658.

MacIntyre, Alasdair. *After Virtue: A Study In Moral Theory* 3rd Edition. South Bend: University of Notre Dame Press, 2018. Audible.

Macy, Joanna. *World as Lover, World as Self: Courage for Global Justice and Ecological Renewal.* Berkeley: Parallax Press, 2007.

Macy, Joanna. "World as Lover, World as Self." In *Engaged Buddhist Reader*, edited by Arnold Kotler, 150-162. Berkeley: Parallax Press, 1996.

Maezumi, Taizan. *On Zen Practice: Body, Breath, and Mind.* Boston: Wisdom Publications, 2002.

Manuel, Zenju Earthlyn. "Embracing the Fullness of Emptiness." Accessed August 20, 2019. https://www.upaya.org/2019/08/manuel-embracing-fullness-emptiness/.

Manuel, Zenju Earthlyn. *The Way of Tenderness: Awakening through Race, Sexuality, and Gender.* Somerville: Wisdom Publications, 2015. Audible.

Martin, David. "Secularisation and the Future of Christianity." *Journal of Contemporary Religion* 20 no. 2 (2005): 145-160.

Mattingly, Cheryl. *Moral Laboratories: Family Peril and the Struggle for a Good Life.* Berkeley: University of California Press, 2014.

Maull, Fleet. *Radical Responsibility: How to Move Beyond Blame, Fearlessly Live Your Highest Purpose, and Become an Unstoppable Force for Good.* Boulder: Sounds True, 2019.

Maull, Fleet. "Straw Breathing for Self-Regulation." Recorded April 18, 2019. https://www.youtube.com/watch?v=YCbAKwI4iEA.

Maull, Fleet. *Dharma in Hell: The Prison Writings of Fleet Maull.* South Deerfield: Prison Mindfulness Institute, 2005.

McMahan, David L. *The Making of Buddhist Modernism*. Oxford, New York: Oxford University Press, 2008.

Metta Institute. Accessed April 20, 2018. https://www.mettainstitute.org.

Mol, Annemarie. *The Logic of Care: Health and the Problem of Patient Choice.* London: Routledge, 2008.

Mohrman, Margaret. "Ethical Grounding for a Profession of Hospital Chaplaincy." *The Hastings Center Report* 38 no. 6 (2006): 18-25.

Monnett, Mikel. "Developing a Buddhist Approach to Pastoral Care: A Peacemaker's View." *The Journal of Pastoral Care & Counseling* 59 no. 1-2 (2005): 57-61.

Myeroff, Barbara. *Number Our Days.* New York: Dutton, 1980.

Myers-Shirk, Susan E. *Helping the Good Shepherd: Pastoral Counselors In a Psychotherapeutic Culture, 1925-1975.* Baltimore: Johns Hopkins University Press, 2009.

Nhat Hanh, Thich. *Peace is Every Step: The Path of Mindfulness in Everyday Life.* New York: Bantam Books, 1991.

Nhat Hanh, Thich. *The Miracle of Mindfulness: A Manual on Meditation.* Boston: Beacon Press, 1987.

Nouwen, Henri. *The Life of the Beloved.* New York: Crossroads Publishing Company, 1991.

Nouwen, Henri. *The Wounded Healer: Ministry in Contemporary Society*. New York: Doubleday Image, 1972.

Ogden, Pat and Janina Fisher, *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment.* New York: W. W. Norton & Co., 2015.

Ostaseski, Frank. *The Five Invitations: Discovering What Death Can Teach Us About Living Fully.* New York: Flatiron Books, 2017.

Packer, Martin. *The Science of Qualitative Research.* New York: Cambridge University Press, 2011.

Pfaff, Kathryn and Adelais Markaki. "Compassionate Collaborative Care: An Integrative Review of Quality Indicators In End-of-Life Care." *BMC Palliative Care* 16 (2017): 1-24.

Powers, John. *Introduction to Tibetan Buddhism.* Ithaca: Snow Lion Publications, 2007.

Porges, Stephen. *The Pocket Guide to the Polyvagal Theory: The Transformative Power of Feeling Safe.* New York: W. W. Norton & Co., 2017.

Puchalski, Christina. "The Role of Spirituality in Healthcare." *Baylor University Medical Center Proceedings* 14 no. 4 (October 2001): 352-357.

Quinn, Naomi. "The Self." *Anthropological Theory* 6 no. 3 (2006): 362-384.

Raab, Kelly. "Mindfulness, Self-Compassion, and Empathy Among Health Care Professionals: A Review of the Literature." *Journal of Healthcare Chaplaincy* 20 no. 3 (2014): 95-108.

Rogers, Carl. *Client-Centered Therapy: Its Current Practice, Implications, and Theory.* London: Constable & Robinson, 2003

Rosch, Eleanor. "The Emperor's Clothes: A Look Behind the Western Mindfulness Mystique." In *Handbook of Mindfulness: Culture, Context, and Social Engagement,* edited by Ronald Purser, David Forbes and Adam Burke, 271-292. New York: Springer, 2016.

Rose, Nikolas. *Inventing Our Selves: Psychology, Power, and Personhood.* Cambridge: Cambridge University Press, 1998.

Rosenberg, Larry. "The Third Messenger: Death Is Unavoidable," *Awake by the Bedside: Contemplative Teachings on Palliative and End-of-Life Care*, edited by Koshin Paley Ellison and Matt Weingast, 215-234. Somerville: Wisdom Publications, 2016.

Rushton, Cynda H. "Ethical Discernment and Action: The Art of Pause." *AACN Advanced Critical Care* 20 no. 1 (2009): 108-111.

Rushton, Cynda H. and Renee Boss. "The May Face of Moral Distress Among Clinicians." *Narrative Inquiry in Bioethics* 3 no. 2 (2013): 89-93.

Rushton, Cynda H., Alfred Kaszniak, and Joan Halifax. "Addressing Moral Distress: Application of a Framework to Palliative Care Practice." *Journal of Palliative Medicine* 16 no. 9 (2013): 1080-1088. https://doi-org.proxy01.its.virginia.edu/10.1089/jpm.2013.0105.

Śantideva. *The Bodhicaryavatara.* Translated by Kate Crosby and Andrew Skilton. Oxford: Oxford Classics, 1995.

Saito, Daisuke et al., "'Stay Tuned': Inter-Individual Neural Synchronization During Mutual Gaze and Join Attention." *Frontiers in Integrative Neuroscience* 4 (November 2010): 1-12.

Salzberg, Sharon. *Lovingkindness: the Revolutionary Art of Happiness.* Boston: Shambala, 1997.

Satter, Beryl. *Each Mind a Kingdom: American Women, Sexual Purity, and the New Thought Movement, 1875-1920.* Berkeley: University of California Press, 1999.

Schmidt, Leigh Eric. *Restless Souls: The Making of American Spirituality.* San Francisco: Harper San Francisco, 2005.

Seager, Richard Hughes. *Buddhism in America.* New York: Columbia University Press, 2000.

Siegel, Daniel. *Aware: the Science and Practice of Presence.* New York: Tarcher Perigee, 2018. Audible.

Siegel, Daniel. *The Mindful Brain: The Neurobiology of Well-Being.* Boulder: Sounds True, 2011a. Audible.

Siegel, Daniel. *The Neurobiology of 'We': How Relationships, the Mind, and the Brain Interact to Shape Who We Are.* Boulder: Sounds True, 2011b. Audible.

Siegel, Daniel. *Mindsight: The New Science of Personal Transformation.* New York: Bantam Books, 2010. Audible.

Siegel, Daniel. "Toward an Interpersonal Neurobiology of the Developing Mind: Attachment Relationships, 'Mindsight,' and Neural Integration." *Infant Mental Health Journal* 22 no. 1/2 (2001): 67-94.

Sinclair, Shane et al. "Compassion: A Scoping Review of the Healthcare Literature." *BMC Palliative Care* 15 (2016a): 1-16.

Sinclair, Shane et al. "Compassion in Health Care: An Empirical Model." *Journal of Pain and Symptom Management* 51 no. 2 (2016b): 193-203.

Singer, Tania and Olga M. Klimecki. "Empathy and Compassion." *Current Biology* 24 no. 18 (2014): R875-R878.

Singer, Tania and Boris Bornemann. "A Cognitive Neuroscience Model: The ReSource Model." In *Compassion: Bridging Practice and Science*, edited by Tania Singer and Matthias Bolz. Leipzig: Max Planck, 2013.

Spezio, Michael. "Forming Identities in Grace: Imitatio and Habitus as Contemporary Categories for the Science of Mindfulness and Virtue." *Ex Auditu* 32 (2016): 125-141.

Spezio, Michael. "Social Neuroscience and Theistic Evolution: Intersubjectivity, Love, and the Social Sphere." *Zygon* 48 no. 2 (June 2013): 428-438.

Spezio, Michael, Gregory Peterson and Robert Roberts. "Humility as Openness to Others: Interactive Humility in the Context of l'Arche." *Journal of Moral Education* (2018): 1-20

Stahl, Ronit. *Enlisting Faith: How the Military Chaplaincy Shaped Religion and State in Modern America.* Cambridge: Harvard University Press, 2017.

Stoller, Paul. *Stranger in the Village of the Sick: A Memoir of Cancer, Sorcery, and Healing.* Boston: Beacon Press, 2004.

Sullivan, Winnifred. *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law.* Chicago: University of Chicago Press, 2014.

Suzuki, Shunryu. *Zen Mind, Beginner's Mind: Informal Talks on Zen Meditation and Practice.* New York: Weatherhill, 2001.

Syman, Stefanie. *The Subtle Body: the Story of Yoga in America.* New York: Farrar, Straus and Giroux, 2010.

Taylor, Charles. "The Polysemy of the Secular." *Social Research* 76 no. 4 (2009): 1143-1166.

Taylor, Charles. *The Ethics of Authenticity*. Cambridge: Harvard University Press, 1991.

Taylor, Charles. *Sources of the Self: The Making of the Modern Identity*. Cambridge: Harvard University Press, 1989.

Travis, Trysh. *The Language of the Heart: A Cultural History of the Recovery Movement from Alcoholics Anonymous to Oprah Winfrey.* Chapel Hill: University of North Carolina Press, 2010.

Treleaven, David. *Trauma-Sensitive Mindfulness: Practices for Safe and Transformative Healing.* New York: W. W. Norton and Co., 2018.

Trungpa, Chögyam. *The Path is the Goal: a Basic Handbook of Buddhist Meditation.* Newark: Audible, 2014. Audible.

Turner, Victor. *The Forest of Symbols: Aspects of Ndembu Ritual.* Ithaca: Cornell University Press, 1967.

Tweed, Thomas. *Crossing and Dwelling: A Theory of Religion.* Cambridge: Harvard University Press, 2006.

Upaya Institute and Zen Center. "Roshi Bernie Glassman." Accessed November 29, 2018. https://www.upaya.org/people/bio/roshi-bernie-glassman/.

Upaya Institute and Zen Center. "Being with Dying Professional Training in End-of-Life Care May 2013." Accessed December 14, 2019. https://www.upaya.org/program/?id=885.

Vago, David. "Mapping Modalities of Self-Awareness in Mindfulness Practice: A Potential Mechanism for Clarifying Habits of Mind." *Annals of the New York Academy of Sciences* 1307 no. 1 (2014): 28-42.

Vago, David and David Silbersweig. "Self-Awareness, Self-Regulation, and Self-Transcendence (S-ART). A Framework for Understanding the Neurobiological Mechanisms of Mindfulness." *Frontiers In Human Neuroscience* 6 (2012): 1-30.

Van Maanen, John. *Tales from the Field: On Writing Ethnography* 2nd Edition. Chicago: University of Chicago Press, 2010.

Varela, Francisco, Evan Thompson and Eleanor Rosch. *The Embodied Mind: Cognitive Science and Human Experience.* Cambridge: MIT Press, 1991.

Varela, Francisco and Jonathan Shearer. "First Person Methodologies: What, Why and How?" *Journal of Consciousness Studies* 6 no. 2-3 (1999): 1-14

Van der Kolk, Bessel. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma.* New York: Penguin Books, 2014.

Walker, Margaret Urban. *Moral Understandings: A Feminist Study in Ethics.* New York and London: Routledge, 1998.

Weber, Max. "Science as Vocation." In *From Max Weber: Essays In Sociology.* Translated by Hans Heinrich Gerth and C. Wright Mills, 129-156. Milton Park, Abingdon, Oxon, New York: Routledge, 2009. Ebook Central - Academic Complete.

Weber, Max. *Protestant Ethic and the Spirit of Capitalism*. Translated by Talcott Parsons. London and New York: Routledge, 1992.

williams, angel Kyodo. "Four Noble Truths: Simple Teachings for Extraordinary Times." Accessed November 1, 2019. https://www.upaya.org/program/four-noble-truths-simple-teachings-for-extraordinary-times-2019/?id=2182.

williams, angel Kyodo and Lama Rod Owens, with Jasmine Syedullah. *Radical Dharma: Talking Race, Love, and Liberation.* Berkeley: North Atlantic Books, 2016.

Wilson, Jeff. *Mindful America: The Mutual Transformation of Buddhist Meditation and American Culture.* Oxford: Oxford University Press, 2014.

Zeidan, Fadel and David Vago. "Mindfulness Meditation-Based Pain Relief: A Mechanistic Account." *Annual New York Academy of Sciences* 1373 no. 1 (2016): 114-127.