The Lived Experience of Buddhist Monastics Engaged in Clinical Pastoral Education in the United States: An Interpretative Phenomenological Analysis

A Dissertation

Presented to

the Faculty of the Department of Buddhist Chaplaincy at

University of the West

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Buddhist Ministry

by

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Spring 2026

Approval Page for Graduate

Approved and recommended for acceptance as a dissertation in partial fulfillment of the requirements for the degree of Doctor of Buddhist Ministry.

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The Lived Experience of Buddhist Monastics Engaged in Clinical Pastoral Education in the United States: An Interpretative Phenomenological Analysis

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I hereby declare that this dissertation has not been submitted as an exercise for a degree at any other institution, and that it is entirely my own work.

Signed Yishan Qian

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Acknowledgements

This dissertation has come to completion through countless causes and conditions, and I am deeply grateful to everyone who has accompanied me along this path—those who guided me, supported me, challenged me, and gently held space for me when I could not do so for myself.

My journey toward this work began in the autumn of 2011, when I traveled to Taiwan to receive the full ordination at Fo Guang Shan. During that time, I also joined the alms-round pilgrimage around the island and witnessed the dedication surrounding the opening of the Fo Guang Shan Buddha Museum. What I encountered there—Buddhism that was vibrant, open, inclusive, and grounded in purity, peace, and joy—has been powerful enough to inspire my entire monastic life. I still remember that during the ordination period, we wrote weekly letters to Venerable Master Hsing Yun, sharing our reflections and inner experiences. In those days, I noticed brochures introducing the University of the West (UWest), and I wrote to the Master expressing a wish that I might one day pursue doctoral studies there. I also asked for a Dharma name as a disciple of Fo Guang Shan, and the Master gave me the name Xin Ben (Heart/Mind of the Original Ground). That name became both a blessing and a lifelong practice.

After I returned to mainland China, the monastic community I lived with went through a major upheaval in 2013. Later, through subsequent circumstances, I entered the Buddhist Foreign Languages program at the Hangzhou Buddhist Academy. From there, I received the opportunity to study abroad, and in the summer of 2015, I arrived at UWest as a graduate student. The first time I stood on the hilltop campus and looked out across the landscape, I suddenly realized that a wish I had made years earlier had imperceptibly

come true. In studying Buddhist Chaplaincy, I have also been trying—again and again—to return to that "original mind" and to live in a way worthy of the name I received.

For all of this, I offer my first and deepest gratitude to Venerable Master Hsing Yun and to Fo Guang Shan for unceasingly giving people confidence, joy, hope, and convenience. I want to express my sincere gratitude to the International Buddhist Education Foundation (IBEF) for the scholarship it has provided me over the years. I also extend sincere thanks to the Hangzhou Buddhist Academy for its spiritual guidance and financial support, and especially to the president of the academy and abbot of Lingyin Monastery, Venerable Guang Quan, for his abiding care, guidance, and encouragement throughout the years.

In the autumn of 2019, I moved to Washington, D.C., where I served as a resident minister at Georgetown University and completed Clinical Pastoral Education (CPE) at MedStar Georgetown University Hospital. Georgetown's multi-religious openness and professional rigor expanded my heart and my horizons in profound ways. Yet the COVID-19 pandemic that followed brought considerable disruption and heightened instability. Like many others, I found myself pulled in different directions, and at one point, it was hard to stay motivated to keep up with my data analysis and dissertation writing; everything felt fragmented and strangely insignificant against the backdrop of suffering and impermanence.

Then, in the spring of 2023, as the pandemic eased, I received the news of Master Hsing Yun's passing. At that moment, it felt as though an essential bond had been severed, and I immediately decided to set everything aside and return to China. Yet the journey was far from the end. Two years later, it was again Venerable Guang Quan's

gentle urging and compassionate insistence that helped me return and complete the dissertation and bring this chapter of my life to a wholesome close. In this sense, completing this work is also an act of gratitude and a gesture of closure—an offering to the unfolding of causes and conditions that carried me here.

I am especially grateful to the Buddhist Chaplaincy Department at UWest and, above all, to my advisor, Rev. Dr. Jitsujo T. Gauthier, who welcomed me back after my interruption and guided me with patience, clarity, and kindness as I returned to this work. I am also grateful to my dissertation committee, Rev. Dr. Victor Gabriel and Dr. Jane Naomi Iwamura, for their careful reading, thoughtful feedback, and constant support.

My sincere thanks go to the professors and instructors with whom I was privileged to study at UWest: Dr. Lewis Lancaster, Dr. William Chu, Dr. Nathan Doshin Woods, Dr. Pamela Ayo Yetunde, and Dr. Daphna McKnight, as well as many visiting and guest teachers whose guidance I also gratefully received. I am also thankful to all staff and administrators at UWest and to my classmates, fellow students, and friends—those I met in classrooms, in the library, in chaplaincy formation, and in the ordinary days that subtly shape a life.

I also offer my deep appreciation to my CPE supervisor, Rev. Donald W. Clem, Jr., and to my cohort peers and the staff chaplains at MedStar Georgetown University Hospital. You showed me what pastoral care and chaplaincy ought to be in a hospital: grounded, competent, compassionate, and deeply human.

My gratitude also goes to Georgetown University Campus Ministry, to Dharmic Life, especially Dr. Brahmachari Vrajvihari Sharan, and to the Buddhist Student Association at Georgetown, as well as to all colleagues and friends there. You showed me

what pastoral care and chaplaincy ought to be on a university campus: intellectually honest, relationally skillful, and truly committed to the flourishing of diverse communities.

Although this academic journey has taken ten years to complete, and in many ways has been carried by vows and causes and conditions unfolding across fifteen years, I know it is only one small milestone. The monastic path, and the path of seeking the Dharma, do not end with a degree; they continue in the ordinary, persistent work of practice, service, learning, and returning—again and again—to what is most essential.

As I step forward from here, I do so with a humble wish for all of us who walk alongside suffering and hope in monasteries, hospitals, classrooms, and homes: may our lives be grounded in well-being, clarity, and peace. May we meet whatever comes—uncertainty, loss, fatigue, and failure—with patience and courage; with understanding that deepens rather than hardens; and with the determination to begin again when we must. And may we never lose the capacity to care, to listen, and to keep faith with the work of compassion until the path itself becomes our offering.

Abstract

The Lived Experience of Buddhist Monastics

Engaged in Clinical Pastoral Education in the United States:

An Interpretative Phenomenological Analysis

By

Yishan Qian

This dissertation investigates the lived experiences of Buddhist monastics participating in Clinical Pastoral Education (CPE) in the United States. Although CPE serves as the predominant training pathway for professional chaplaincy in North American healthcare, and Buddhist participation in chaplaincy is growing, the experiences of Buddhist monastics, whose formation is shaped by renunciation, Vinaya observance, and contemplative practice, remain largely unaddressed in empirical research. Employing Interpretative Phenomenological Analysis (IPA), this study addresses that gap through semi-structured interviews with seven Buddhist monastics representing diverse traditions, cultural backgrounds, and levels of CPE training.

Analysis following the six-step IPA process yielded six superordinate themes: the negotiation of dual identities; the transformation of emotional awareness; the application and adaptation of Buddhist concepts in clinical contexts; the navigation of cultural and religious difference; the distinctive contributions of Buddhist monastics to chaplaincy; and the vision for Buddhist chaplaincy training. Findings indicate that CPE functions as a transformative formation—professional, personal, emotional, and spiritual—while

requiring participants to engage in ongoing identity work through diverse strategies of integration, differentiation, and contextual expression. Participants demonstrated sophisticated processes of Dharma localization, translating Buddhist teachings into accessible clinical forms without reducing their essence. Several participants experienced emotional reclamation—recovering suppressed affective capacities—which deepened rather than departed from their Buddhist practice.

Three theoretical contributions are advanced: integrative negotiation (describing how monastics hold dual roles), emotional reclamation (the recovery of emotional availability), and Dharma localization (the adaptation of Buddhist wisdom for clinical contexts). Implications address CPE educators, Buddhist communities, healthcare institutions, and Buddhist monastics considering CPE. The study concludes that while individual monastics succeed in current structures, systemic changes are needed to make chaplaincy education genuinely multifaith, and that CPE can serve not as a departure from monastic identity but as its lived expression in service of suffering beings.

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Chapter One:

Introduction

Background and Context of the Study

Clinical Pastoral Education (CPE) has become one of the most influential models for forming professional spiritual caregivers in North American healthcare. Developed as an action-reflection approach to pastoral formation, CPE typically integrates supervised clinical practice, structured self-reflection on one's spiritual care encounters, and interpersonal learning within a peer group. In contemporary settings, CPE is not only a training modality but also a key gateway into professional chaplaincy, shaping how spiritual care is conceptualized, taught, evaluated, and credentialed.[1] As healthcare institutions have increasingly emphasized whole-person care and responsiveness to spiritual distress, chaplaincy departments have expanded and professionalized, and CPE has served as a central mechanism for preparing chaplains to function ethically and competently within complex medical systems.[2]

At the same time, North American healthcare is marked by growing religious and cultural diversity. Patients and families bring various spiritual and religious worldviews to their experiences of illness, suffering, loss, and end-of-life decision-making. Chaplains are thus expected to be grounded in their own formation and to provide compassionate, patient-centered care in pluralistic contexts. This interreligious reality has resulted in

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[1] Jitsujo T. Gauthier et al., "The Path to Buddhist Chaplaincy in the United States," in *Refuge in the Storm: Buddhist Voices in Crisis Care*, ed. Nathan Jishin Michon (Berkeley: North Atlantic Books, 2023), 223–32.

[2] Robert L. Klitzman, *Doctor, Will You Pray for Me? Medicine, Chaplains, and Healing the Whole Person* (New York: Oxford University Press, 2024).

shifts in chaplaincy education and practice, moving from traditions of explicitly Christian pastoral identity to broader frameworks of spiritual care that emphasize presence, meaning-making, and cultural humility.[3] In this evolving landscape, Buddhist perspectives and practices have become more visible in health care settings, both through the mindfulness-based interventions and through the emergence of Buddhist-informed spiritual care.[4]

Along with these institutional changes, Buddhist chaplaincy has also developed as a distinct and expanding field. Across Buddhist seminaries, universities, and other dharma-related institutions, training programs have begun to prepare chaplains and spiritual caregivers rooted in Buddhist traditions while capable of serving diverse populations.[5] For many aspiring chaplains, CPE is a key component of this formation pathway. Importantly, Buddhist participation in chaplaincy is not limited to lay practitioners. Buddhist monastics—monks and nuns whose lives are shaped by renunciant vows, communal discipline, and lineage-based spiritual training—are also entering CPE programs.[6] They bring with them significant questions of formation, identity, and translation: What particular pastoral and professional histories shape a training model that serves (or does not serve) the needs of monastics? How do they

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[3] Robert Klitzman, "How Chaplains Can Help the Fractured U.S. Health Care System," STAT, published November 14, 2024, https://www.statnews.com/2024/11/14/chaplains-hospitals-health-care-burn-out-religion-mortality/.

[4] Seigen Yamaoka, "Spirituality and Spiritual Care: A Buddhist Perspective," *Reflective Practice: Formation and Supervision in Ministry* 33 (2013): 1–10.

[5] Jitsujo T. Gauthier, "Buddhist Chaplaincy," in *The Oxford Handbook of Buddhist Practice*, ed. Kevin Trainor and Paula Arai (New York: Oxford University Press, 2022), 564–80, https://doi.org/10.1093/oxfordhb/9780190632922.013.34.

[6] Bhante Kusala, "Can a Buddhist Monk Become a Chaplain?" Harvard Divinity Bulletin, accessed March 11, 2026, https://bulletin.hds.harvard.edu/can-a-buddhist-monk-become-a-chaplain/.

integrate CPE's emphasis on self-disclosure, learning through interpersonal processes, and professional boundary-setting with their monastic discipline and vocation? What resources do monastics have to negotiate clinical suffering, institutional constraints, and interreligious expectations?

At the University of the West, graduate students in the Buddhist Chaplaincy programs are encouraged to complete CPE training, and a minimum of one unit of CPE is required for admission to the Doctor of Buddhist Ministry program.[7] For many students, particularly those with a traditional Buddhist monastic background, this academic requirement often feels unfamiliar and uncomfortable. Monastic training usually includes meditation, chanting, and ethical precepts, but not clinical language, psychological assessment, verbatim writing, or group feedback on pastoral presence. When I first came across this requirement as a student in the program, a Buddhist nun from China, I felt both resistance and curiosity. The prospect of entering a hospital, sitting with acutely suffering individuals, and being subject to supervision and recording raised internal hesitation. At the same time, I was curious about how my Buddhist training would manifest in such a clinical setting. Before enrolling, I consulted senior students who had completed CPE, asking about their actual experiences and the lessons they learned. Their narratives were highly valuable, and it occurred to me that a more systematic and respectful method of capturing those stories would benefit future students, particularly

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[7] "Buddhist Chaplaincy Graduate Programs," University of the West, accessed March 11, 2026, https://www.uwest.edu/academics-buddhist-chaplaincy-grad/. One unit of CPE is commonly 10–12 weeks long and includes 300 hours of clinical work with patients/clients and 100 hours of continuing education, which includes self-study, one-on-one sessions with your supervisor, and group work with your supervisor and cohort. For more details, see Daphna McKnight, "The ABCs of CPE – What is CPE & How Do I Apply?" International Buddhist Chaplains Foundation, published April 6, 2020, https://ibcfusa.org/wp-content/uploads/2020/04/The-ABCs-of-CPE-v.-4.6.20.pdf.

monastics who might feel even greater uncertainty about CPE. Consequently, I decided to transform this personal inquiry into a formal study.

Problem Statement

Buddhist monastics bring distinctive strengths to clinical spiritual care. Their formation often involves long-term contemplative practice, ethical discipline, familiarity with teachings on suffering and impermanence, and communal patterns of service; these resources can support ways of being present and compassionate that are particularly relevant in healthcare contexts. But monastic formation also can produce particular tensions when situated in healthcare institutions and within the pedagogical environment of CPE. Challenges may emerge from the religious minority status of monastics, from cultural misunderstandings, or from expectations shaped by dominant norms of chaplaincy. They may also experience practical constraints such as institutional policies, documentation practices, clinical hierarchies, and definitions of professional roles, all the while being subject to monastic precepts, community expectations, and lineage commitments. Moreover, Buddhist monastics may struggle to discern how (and whether) Buddhist teachings are articulated explicitly in the context of patient care, especially when patients are not Buddhist or when clinical contexts emphasize non-proselytizing, patient-directed spiritual language.

CPE itself is a highly relational and reflective learning environment. Trainees are commonly evaluated not only on their clinical competence but also on their self-awareness, use of self, emotional attunement, and ability to engage with feedback within a cohort. These elements can be transformative, but they can also be experienced as

disorienting or culturally coded, depending on the trainee's prior formation and role expectations.[8] For Buddhist monastics, whose vocational identity may already be strongly formed through ordination, communal discipline, and contemplative training, CPE may function differently than it does for trainees whose spiritual authority is primarily shaped through academic theological education or congregational ministry.[9] Understanding what CPE "does" for monastics—how it is received, interpreted, and integrated—therefore requires careful attention to lived experience rather than assumptions derived from other populations.

Despite the growing presence of Buddhists in chaplaincy and the expanding interest in Buddhist spiritual care, the voices of Buddhist monastics within CPE remain insufficiently centered in empirical research. Much of the existing discourse on chaplaincy formation has focused on general competencies, professional standards, or interfaith models without closely examining how specific religious vocations, particularly renunciant ones, experience the formative processes of CPE.[10] Questions about how monastics negotiate the intersection of monastic discipline, intra- and cross-traditional identity formation, and the institutional requirements of CPE have not been explored systematically.

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[8] Mark Power, "Buddhist Chaplaincy in a Christian Context: A Personal Journey," in *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*, ed. Cheryl A. Giles and Willa B. Miller (Boston: Wisdom Publications, 2012), 69.

[9] Bryan Scoville-Pope, "The Three Lotuses: Knowledge, Ethics, and Compassion as a Framework for the Education of Buddhist Clergy in the West" (PhD diss., University of the West, 2018).

[10] See, for example, Jitsujo T. Gauthier, "Formation and Supervision in Buddhist Chaplaincy," *Reflective Practice: Formation and Supervision in Ministry* 37, no. 1 (2017): 185–201; and Zhen Guan, "Buddhist Chaplaincy in the United States: Theory-Praxis Relationship in Formation and Profession," *Journal of International Buddhist Studies* 13, no. 1 (2022): 44–59.

This absence raises practical concerns as well as academic ones. CPE educators may be ill-prepared to support Buddhist monastic students if they do not have an empirical grounding, particularly when there are conflicts between monastic rules and CPE expectations. The language of supervision is infused with Christian theological and psychological assumptions that may not easily translate into Buddhist frameworks. Ethical frameworks embedded in CPE curricula often do not necessarily align with Buddhist monastic ethics. Interfaith dialogue in the context of CPE's interfaith learning environment, a setting where students from Christian backgrounds routinely evoke Christian concepts, may produce disorientation and require interpretive work that has not been documented or supported.

In short, existing knowledge about CPE experiences is largely grounded in Christian or broadly interfaith contexts. What remains missing is empirical research that places Buddhist monastics at the center and attends to the specific contours of their experience—particularly how monastic formation, Vinaya observance, and Buddhist worldviews intersect with CPE's structures, expectations, and professional norms. Accordingly, this study aims to address this gap by developing a phenomenological understanding of how Buddhist monastics in the United States experience, interpret, and make meaning of their participation in CPE, thereby laying a foundation for more responsive training, supervision, and institutional support.

Methodological Orientation

To this end, from the outset the aim was to foreground participants' own voices and to understand their experiences from the inside—embracing their richness, ambiguity,

and even contradiction. This led to the adoption of a hermeneutic approach, grounded in the view that meaning is not simply "out there" waiting to be collected, but is co-constructed through dialogue: between the researcher and the participant, between the participant and their lived experience, and between the researcher's Buddhist lens and the participant's unique story. Accordingly, the researcher's role is not to claim a final, objective truth, but to support a deep, thoughtful, and respectful interpretation of what CPE means to those who have lived it. My further reading into qualitative research suggested that Interpretative Phenomenological Analysis (IPA) was an approach that perfectly aligned with this hermeneutic commitment.[11]

This study, using an IPA framework, adds to the empirical literature by exploring the lived experience of Buddhist monastics in U.S. CPE programs. IPA is particularly well suited to exploring complex, relational, and meaning-laden processes of formation. Although it originated in psychology, it is now widely used in health, education, and pastoral studies.[12] Its goal is to explore in depth how individuals make meaning of a particular experience, such as a major life event, a life transition, or a training program like CPE. There are three important features of IPA: first, it is phenomenological, centered on lived experience and participants' perspectives; second, it is interpretative, recognizing that the researcher actively participates in making sense of the participants' own sense-making rather than claiming pure objectivity; third, it is idiographic, committed to in-depth, case-by-case analysis before identifying patterns across

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[11] Jonathan A. Smith, Paul Flowers, and Michael Larkin, *Interpretative Phenomenological Analysis: Theory, Method and Research* (London: SAGE Publications, 2009).

[12] Edward J. Noon, "Interpretive Phenomenological Analysis: An Appropriate Methodology for Educational Research?" *Journal of Perspectives in Applied Academic Practice* 6, no. 1 (2018): 75–83, https://doi.org/10.14297/jpaap.v6i1.304.

participants. This idiographic commitment honors each person's story as unique, rather than rushing to averages or generalizations.[13] Thus, IPA became the backbone of the study design.

The researcher's training in Buddhist ministry and engagement with U.S. clinical spiritual care contexts further shape this study. My monastic formation, ongoing practice, and commitment to Buddhist ministry orient me toward questions of suffering, compassion, and spiritual accompaniment in contexts of illness, loss, and moral distress. At the same time, my academic training situates me within U.S. higher education and within a professional chaplaincy landscape in which CPE functions as a key credentialing and formation pathway. Because this study employs IPA, reflexivity is not peripheral but central: participants interpret their own experiences, and I, as researcher, interpret participants' interpretations.[14] My standpoint, therefore, influences the framing of the study, the interview relationship, and the analytic decisions that shape the final account.

My interest in Buddhist monastics undergoing CPE arises from both vocational concern and scholarly curiosity. As a Chinese monastic preparing for Buddhist ministry in the United States, I am attentive to how spiritual care is trained, authorized, and practiced within healthcare institutions. I am also curious about how Buddhist teachings and practices are translated into clinical contexts without being reduced to generic 'mindfulness' or divorced from their ethical and soteriological foundations. The study originated in an interest in understanding how monastics experience CPE as a formative environment, what challenges and possibilities they encounter, and what forms of support may be needed for sustainable and ethically coherent formation.

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[13] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 7–24.
[14] Smith, Flowers, and Larkin, 187.

At the same time, I recognize that there are commitments I might be inclined to prioritize, such as an assumption that monastic training is preparation for clinical caregiving or a hope that CPE can be more effectively adapted for Buddhist trainees. IPA requires that these orientations be held with awareness and that I remain open to experiences that complicate or contradict my expectations, including accounts of mismatch, struggle, or disappointment.

This section aims to provide readers with the contextual background for understanding the positioning of this study—a key feature of IPA that acknowledges the researcher's active role in co-constructing meaning. Chapter 3 will detail specific strategies for reflexivity as a methodological practice and a means of ensuring research quality.

Purpose of the Study

CPE functions as a primary training pathway for clinical chaplaincy and professional spiritual care, emphasizing supervised clinical practice, interpersonal learning, and structured theological/spiritual reflection. However, Christian and broader interfaith chaplaincy histories have largely shaped the field's dominant pedagogical assumptions, professional norms, and formative narratives.[15] As Buddhist monastics increasingly enter CPE programs, there remains a need for research that foregrounds their perspectives: What is the actual lived experience of CPE for Buddhist chaplaincy students? What does this training mean, what does it do, and how does it shape the practitioner? Thus, the research question emerged naturally, especially regarding how

[15] Gauthier et al., "Path to Buddhist Chaplaincy," 224.

they experience CPE's training culture, how they negotiate role expectations within healthcare institutions, and how they draw on Buddhist teachings and practices in both clinical encounters and reflective learning processes.

The purpose of this study is to explore and interpret the lived experience of Buddhist monastics engaged in CPE, with a focus on how they understand their spiritual and professional formation within North American healthcare contexts. Employing IPA as its methodological framework, this study seeks to understand not merely what happens to Buddhist monastics during CPE but how they themselves make sense of those experiences, assign meaning to them, and integrate them into their ongoing formation as monastics and as spiritual caregivers.

Three related dimensions animate this inquiry. First, the study attends to lived experience in its concrete, situated particularity, that is, the specific encounters, relationships, and events that comprise the CPE trajectory for each participant. Second, the study investigates the processes of meaning-making—how participants make sense of these experiences in the context of their Buddhist training, monastic vows, and personal histories. Third, the study engages in interpretive work, recognizing that participants' own acts of interpretation are themselves the object of analysis and that the researcher's interpretive framing inevitably shapes the findings presented.

Guided by IPA, the study seeks to investigate how Buddhist monastics make meaning of CPE as a formative experience, how they negotiate identity and role tensions that arise at the intersection of monastic vocation and clinical caregiving, and how Buddhist frameworks function as lived resources in CPE learning. The study does not evaluate the effectiveness of CPE against external standards but instead prioritizes first-

person accounts from participants to better comprehend their interpretive processes: what they experience as supportive or constraining, how they describe growth and challenge, and how they articulate congruence or dissonance between renunciate commitments and institutional demands.

In this dissertation, I attend closely to participants' stories and interpretations to illuminate how Buddhist monastics experience CPE as a formative environment, how they navigate institutional expectations while maintaining monastic integrity, and how they draw on Buddhist frameworks in clinical and reflective learning. This work contributes to current discussions on religious diversity in spiritual care, Buddhist chaplaincy education, and the future of CPE in multifaith health care settings.

A further purpose of the study is practical and constructive. This dissertation seeks to identify common experiences among monastics, including shared challenges, effective strategies, and valuable resources, to inform Buddhist chaplaincy training, support CPE programs for Buddhist trainees, and enrich the discourse on religious diversity in clinical spiritual care. In this way, the study adds to the body of knowledge on Buddhist ministry and spiritual care by giving an empirically based, interpretive account of how monks participate in CPE and what that means for training, practice, and professional identity.

Research Questions

Three research questions guide this study, which are formulated to be aligned with IPA's emphasis on lived experience and meaning-making and also to be closely

related to the realities of CPE training and clinical practice. These questions are formulated as follows: one main research question and two sub-questions:

Central question: How do Buddhist monastics experience and make meaning of their participation in CPE?

This question investigates participants' overall experience of CPE and the meanings they construct around it. It attends to how monastics interpret the purpose and character of CPE, how they experience core pedagogical structures (e.g., supervision, peer process groups, evaluation, and feedback), and how they narrate growth, challenges, surprises, and moments of resonance or dissonance. The emphasis is on participants' interpretations of what CPE is doing in their formation rather than on externally defined measures of success.

Sub-question 1: How do Buddhist monastics negotiate their dual roles as Buddhist renunciates and clinical spiritual caregivers within healthcare institutional contexts?

The question concerns identity work and role negotiation as monastics navigate healthcare systems. It examines how participants negotiate institutional norms and professional expectations (e.g., boundaries, documentation, interdisciplinary teamwork, chaplaincy standards, interfaith care) with monastic commitments and ethical disciplines. It further inquires as to how monastics express alignments and tensions between renunciate identity and caregiver roles, as well as what strategies they develop to maintain vocational integrity in institutional contexts.

Sub-question 2: How do Buddhist monastics draw on Buddhist teachings and practices in clinical encounters and reflective learning within CPE?

This question examines how Buddhist resources function in both bedside practice and CPE's reflective processes. It explores how participants mobilize Buddhist teachings, values, stories, texts, and practices (e.g., compassion, mindfulness, non-harming, impermanence, and suffering) when responding to patients, families, and staff, as well as how they interpret these encounters through CPE learning practices such as verbatims, supervision, and group reflection. Particular attention is given to how monastics describe translation and discernment—what feels clinically workable, what feels constrained by context, and how Buddhist frameworks shape their understanding of appropriate, ethical, and effective spiritual care.

Together, these questions provide an integrated framework for examining Buddhist monastics' CPE experiences at three interrelated levels: (1) the program as a lived formative environment, (2) the institutional negotiation of monastic and professional caregiver roles, and (3) the practical and reflective use of Buddhist resources in clinical training.

IPA typically does not aim to prove an argument, but rather to present and interpret the meaning structure of lived experience. Grounded in the experiential accounts of Buddhist monastics interviewed for this study, this dissertation advances a central interpretive claim: CPE in the United States constitutes a deeply formative yet ambivalent space for Buddhist monastics in the United States. While CPE can help Buddhist monastics grow professionally and emotionally and improve their ability to care for people from different religions, it also forces them to confront important conflicts between their monastic identity, Buddhist beliefs, and the usual expectations of healthcare chaplaincy training. Through these negotiations, Buddhist monastics do not

simply adapt to CPE; they actively reinterpret, translate, and localize Buddhist teachings and monastic commitments within clinical and educational contexts, thereby reshaping both their own formation and the possibilities of pluralistic spiritual care.

Consistent with IPA's commitment to openness, the following working propositions are offered not as hypotheses to be tested but as provisional sensitizing orientations that guided data collection and analysis and remained subject to revision throughout the study: (1) Buddhist monastics are likely to experience CPE as simultaneously formative and tension-producing, rather than as uniformly affirming or marginalizing. (2) The core pedagogical structures of CPE (supervision, peer process, and clinical encounter) may function as catalysts for both identity negotiation and affective development within monastic formation. (3) Participants may engage in purposeful translation and localization of Buddhist teachings to meet the nonsectarian and pluralistic norms of U.S. healthcare chaplaincy, thereby reshaping both their pastoral practice and their self-understanding as monastics. (4) The outcome of CPE participation may be less a settled "integration" than an ongoing, context-dependent practice of discernment that is mediated by lineage/teacher support, institutional setting, and prior ministry experience.

These working propositions serve as interpretive lenses that allow the analysis to remain grounded in the concrete, situated accounts of Buddhist monastics. Therefore, we present the findings as a rich, textured understanding of how CPE becomes a site of vocational and spiritual negotiation. What ultimately matters is not whether the propositions hold in a nomothetic sense, but how they illuminate the particular, context-dependent meanings that monastic trainees themselves attribute to their CPE experiences. This idiographic commitment, central to the IPA, means that the dissertation will respect

the complexity and diversity of monastic voices rather than subsuming them within a single explanatory framework.

Significance of the Study

This study is significant because it addresses a gap in clinical spiritual care education by addressing an emerging and underexplored area: the lived experience of Buddhist monastics in CPE. As healthcare institutions in North America become increasingly religiously diverse, chaplaincy and spiritual care departments likewise serve patients, families, and staff whose spiritual lives extend beyond historically Christian categories. Within this changing landscape, Buddhist monastics are participating in CPE in growing numbers and contributing to the development of Buddhist chaplaincy.[16] Yet the normative assumptions embedded within CPE—its pedagogical language, professional socialization processes, and models of spiritual authority—have been shaped primarily by Christian and interfaith chaplaincy histories. Thus, a targeted, interpretive investigation of how Buddhist monastics experience, interpret, and negotiate CPE is timely and needed.

This research adds to the scholarship on CPE and chaplaincy formation by drawing attention to a participant group often overlooked in empirical studies: Buddhist monastics. Existing Buddhist chaplaincy literature has largely focused on curricular ideals, philosophical foundations, or descriptive accounts of Buddhist care practices.[17] Less frequently studied are the developmental processes of CPE as experienced by monks

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[16] Gauthier, "Buddhist Chaplaincy," 566.

[17] Cheryl A. Giles and Willa B. Miller, eds., *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work* (New York: Oxford University Press, 2015).

and nuns, in particular how monastic identity intersects with the structures of clinical training, such as supervision, peer feedback, performance assessment, and professional competency frameworks. Using IPA, this study provides a detailed account of meaning-making, of how participants understand CPE not only as skills training but also as a relational and existential process of formation. The findings have the potential to expand current understandings of CPE by showing how its methods are taken up, reinterpreted, or pushed back against by monastics whose vocational commitments and spiritual disciplines may not align with dominant chaplaincy narratives.

Second, the study empirically examines how clinical settings mobilize Buddhist teachings and practices, contributing to Buddhist ministry and practical theology.[18] Rather than considering Buddhist concepts (e.g., suffering, impermanence, compassion, emptiness) as abstract doctrines, the study examines the way monastics employ these resources in actual clinical encounters and in CPE's reflective learning processes. In so doing, it contributes to a practice-based understanding of Buddhist spiritual care: how Buddhist frameworks operate as interpretive tools in the constraints and demands of contemporary healthcare.

This study also has significance for professional practice and education. CPE programs aim to form caregivers who can offer spiritually integrative, ethically grounded, and culturally responsive care. However, training environments can unintentionally presume particular cultural or theological norms—for example, assumptions about religious language, approaches to authority and ordination, modes of self-disclosure, or expectations about pastoral identity development. By documenting how Buddhist

[18] Lozang Trinlae, "Prospects for a Buddhist Practical Theology," *International Journal of Practical Theology* 18, no. 1 (2014): 7–22, https://doi.org/10.1515/ijpt-2014-0002.

monastics experience CPE structures (e.g., verbatims, group process, supervisory relationships) and how they negotiate institutional expectations (e.g., professional boundaries, documentation, interdisciplinary teamwork), this research can help CPE educators and supervisors better recognize both the assets Buddhist monastics bring and the specific points where additional support or contextual sensitivity may be needed.

Moreover, the study can contribute to the emerging field of Buddhist chaplaincy formation. Buddhist chaplaincy programs and Buddhist ministry degrees are emerging quickly but often have to work with CPE requirements and healthcare credentialing pathways. The results of this study may help identify what monastics find most formative within the CPE, what appears not to be compatible with monastic vocation, and what pedagogical, supervisory, or institutional adaptations might encourage more coherent formation without compromising professional standards. This can support Buddhist communities, academic programs, and training centers in developing curricula, mentorship models, and field education structures that prepare monastics for clinical spiritual care while honoring monastic discipline and lineage commitments.

The study also has implications for religious diversity, inclusion, and equity in health care institutions. Chaplaincy departments are increasingly asked to work in inter-religious and pluralistic settings where caregivers are expected to be able to serve patients across traditions while staying rooted in their own formation. Buddhist monastics may face particular dynamics of minority religious representation, professional legitimacy, and institutional power. Grasping these dynamics can assist healthcare institutions in developing more inclusive policies and team cultures of spiritual care, ultimately

enhancing the spiritual support for Buddhist patients and for non-Buddhist patients who benefit from Buddhist-informed approaches to presence, suffering, and compassion.

The study offers an understanding of the practice and communication of "Buddhist spiritual care" in contexts where patients and staff may be less familiar with Buddhist categories. Exploring how monastics translate, or bracket, Buddhist teachings in clinical and reflective learning environments can help chaplains and educators articulate clinically appropriate and spiritually authentic Buddhist-informed care.

Finally, this study has methodological implications in the application of IPA to the study of spiritual care formation. CPE inherently involves experiential, reflective, and relational aspects, as well as complex identity development and meaning-making, which purely outcome-oriented or competency-only approaches cannot adequately capture. IPA is particularly well-suited to understanding how participants make sense of formative experiences, make meaning of struggle and growth, and narrate their sense of vocation and practice. This dissertation uses IPA to explore how Buddhist monastics experience CPE, and demonstrates the value of interpretive phenomenology for studying chaplaincy training in a variety of religious contexts.

In summary, this study is significant because it (1) fills a gap in empirical research on CPE by centering Buddhist monastics' lived experiences; (2) advances Buddhist ministry and Buddhist spiritual care scholarship through practice-based, interpretive insight; (3) provides actionable implications for CPE educators, supervisors, and emerging Buddhist chaplaincy training programs; and (4) supports broader institutional goals of religious inclusion and spiritually responsive healthcare. By clarifying how Buddhist monastics experience CPE, negotiate dual roles, and draw on

Buddhist resources in clinical encounters and reflective learning, the study aims to contribute to more equitable, effective, and spiritually grounded clinical education and care.

By demonstrating that CPE is a deeply formative yet ambivalent space in which Buddhist monastics negotiate, reinterpret, and localize their monastic commitments within pluralistic clinical settings, this study invites both CPE educators and Buddhist communities to reimagine clinical training as a site of vocational formation, interreligious learning, and mutual transformation.

Dissertation Overview

The study was motivated by a recognized gap in the empirical literature: while Buddhist participation in professional chaplaincy is growing in the United States, and while CPE remains the standard training pathway for spiritual care in North American healthcare settings, the lived experiences of Buddhist monastics who undertake CPE have not been systematically investigated. This study responds to that gap by providing the first interpretative phenomenological analysis of how Buddhist monastics experience, interpret, and make meaning of their participation in CPE.

To achieve the research objectives, the study employed IPA as its methodological framework. Seven participants—John, Dora, Hope, Faye, Lynn, Wynn, and Mona—were recruited through purposive sampling. They came from different Buddhist traditions, different cultural backgrounds, different levels of training, and different clinical settings. Data were collected using online semi-structured interviews and transcribed verbatim.

Analysis was carried out according to the six-step process of IPA outlined by Smith, Flowers, and Larkin.

The analysis produced six superordinate themes: (1) the negotiation of dual identities (monastic and chaplain), (2) the transformation of emotional awareness, (3) the application and adaptation of Buddhist concepts in clinical contexts, (4) the navigation of cultural and religious difference, (5) the distinctive contributions of Buddhist monastics to chaplaincy, and (6) the vision for Buddhist chaplaincy training. These themes were explored through idiographic case studies and cross-case synthesis, resulting in a nuanced account of how participants made meaning of their CPE experiences.

The findings yielded five principal conclusions. (1) CPE functions for Buddhist monastics as a form of transformative formation that extends beyond professional skill development to encompass personal, emotional, and spiritual growth; participants emerge not merely as more competent clinicians but as transformed individuals; (2) the negotiation of dual identities (monastic and chaplain) is not optional but inherent to Buddhist monastic participation in CPE, and participants developed diverse strategies of integration, differentiation, and contextual identity rather than any single "correct" model; (3) participants engaged in sophisticated processes of Dharma localization—adapting and translating Buddhist teachings for clinical contexts in ways that preserved their essence while making them accessible to patients who may not share Buddhist frameworks; (4) several participants experienced emotional reclamation (such as recovering the capacity to cry or discovering previously unrecognized emotional walls), which represented not a departure from Buddhist practice but its deepening, as they integrated emotional awareness with meditative stability; (5) while individual monastics can and do succeed in

CPE as currently structured, there remains a need for structural changes that would better accommodate Buddhist participants and, more broadly, transform chaplaincy education into something genuinely multifaith.

Together, these findings demonstrate that for Buddhist monastics, CPE is far more than a professional credentialing pathway. It is a transformative encounter that challenges, deepens, and sometimes radically reorients their understanding of both monastic identity and compassionate service. The study concludes with implications for CPE educators, Buddhist monastic communities, and future research and recommendations for structural changes that would support greater inclusion of Buddhist voices in spiritual care training.

The dissertation is divided into six chapters, which together provide a thorough investigation of the lived experience of Buddhist monastics engaged in CPE in the United States. The study is organized to follow the research process, beginning with the introduction and background, followed by the literature review, methodology, and findings. It then discusses the findings in relation to the literature and concludes with implications and recommendations for future research.

Chapter One: Introduction situates the study within the broader context of spiritual care education and Buddhist engagement in chaplaincy. The chapter begins with the background and context of the study. It describes how CPE became the dominant paradigm for professional spiritual care training in North America and how Buddhist Chaplaincy developed as a separate discipline. I then explain the problem this research addresses and the methodological approach I have taken. It considers the rationale for the research process and notes my positionality as a Buddhist monastic and international

student. Thereafter, I state the purpose of the study and the three research questions. The significance of the study for multiple stakeholders is discussed. The analytic process is also described briefly, and the six superordinate themes and key conclusions are briefly presented. Key terms are defined to avoid conceptual ambiguity, and the chapter ends with an overview of the dissertation.

Chapter Two: Literature Review reviews scholarship from a variety of disciplines relevant to understanding the experiences of Buddhist monastics in CPE. It surveys the history and current development of CPE, including its origins in the work of Anton Boisen, its institutionalization, and its present scope. The chapter then discusses the development and current status of Buddhist chaplaincy, the historical roots of Buddhist Chaplaincy in the Buddhist traditions, and the distinctive characteristics of Buddhist spiritual care. It also discusses Humanistic Buddhism and Engaged Buddhism as movements that shape the Buddhist chaplaincy's understanding of compassionate action. The chapter also reviews literature on professional identity, roles, and boundaries in chaplaincy, as well as the theoretical frameworks used to study identity work and boundary negotiation. It also includes cross-cultural and interfaith encounters in healthcare from the perspectives of religious diversity, interfaith collaboration, and translation of concepts. The chapter concludes with the gaps that this study intends to fill: (1) lack of empirical research on Buddhist participants in CPE, (2) tensions between monastic formation and CPE methodology that have not been explored, and (3) the need for phenomenological approaches.

Chapter Three: Methodology outlines the interpretative phenomenological approach employed in this research. It begins by explaining the theoretical and

philosophical underpinnings of IPA and the three main pillars of IPA: phenomenology, hermeneutics, and idiography. The chapter goes on to explain the research design and the recruitment processes of the participants. Seven participants were selected through purposive sampling from different Buddhist traditions, cultural backgrounds, and levels of CPE training. It also covers the use of semi-structured interviews, including the interview schedule and procedures for conducting them online. Here we describe in detail the six stages of the IPA analytic process: reading and re-reading, initial noting, developing emergent themes, searching for connections across emergent themes, moving to the next case, and identifying patterns across cases. The chapter further discusses the role of in vivo and thematic coding in relation to the appendices, which document the coding trail. Finally, the chapter addresses methodological integrity and ethical concerns, including how to ensure quality and rigor, researcher reflexivity throughout the process, and ways to protect participant confidentiality and well-being.

Chapter Four: Findings presents the interpretative phenomenological analysis of lived experiences of seven Buddhist monastics in CPE. The chapter begins with an overview and then moves on to the idiographic findings, which provide a detailed case-by-case analysis of each participant: John, Dora, Hope, Faye, Lynn, Wynn, and Mona. Each case study begins with the background and context of the participant and then moves on to the experiential themes that emerge from that person's account while preserving the particularity of each voice. The cross-case analysis subsequently reveals themes of convergence and divergence across participants, grouped into six superordinate themes: (1) the negotiation of dual identities, (2) the transformation of emotional awareness, (3) the application and adaptation of Buddhist concepts in clinical contexts, (4)

the navigation of cultural and religious difference, (5) the distinctive contributions of Buddhist monastics to chaplaincy, and (6) visions for Buddhist chaplaincy training. The themes are systematically summarized in a table, and the findings are mapped directly onto the three research questions.

Chapter Five: Discussion provides a more in-depth interpretative analysis of the findings in relation to the research questions and existing literature. This chapter begins with a summary of the findings, before considering each research question in turn. Rather than a descriptive overview, the chapter considers the underlying dynamics, tensions, and implications of the findings. It draws on relevant scholarship to situate the study within conversations on Buddhist chaplaincy supervision, minority religious representation in CPE, the application of Buddhist principles in clinical settings, and professional identity formation. The chapter makes three theoretical contributions: a model of integrative negotiation, which describes how monastics negotiate dual identities; the concept of emotional reclamation, which captures the recovery of emotional experience that may have been suppressed through monastic and cultural conditioning; and the framework of Dharma localization, which describes how Buddhist teachings are adapted and translated for clinical settings. It also outlines implications for practice for (a) CPE educators and supervisors, (b) Buddhist monastic communities, (c) Buddhist chaplaincy training programs, (d) healthcare institutions, and (e) Buddhist monastics considering CPE.

Chapter Six: Conclusion provides an overall summary of the study and contributions. It begins with an overview of the study and then key conclusions around five core insights: CPE as transformative formation; identity negotiation as core to Buddhist monastic participation; Dharma localization as a form of skilled clinical

practice; emotional reclamation as integration rather than departure; and the need for structural change. The chapter covers the study's contributions to knowledge on the empirical, theoretical, methodological, and practical levels. It also acknowledges limitations of the study, such as sample size, language issues, the design at a single point in time, and researcher positionality. Future research directions are then suggested, such as studies with other Buddhist populations, longitudinal studies, comparative studies across minority traditions, outcome studies, and studies of institutional change. Finally, the chapter presents Dharma and ministerial reflections on the intrinsic tension between self-identity and non-self (*anattā*), the disjuncture between my initial conceptual assumptions and the lived experiential findings, and an interpretation of the findings through the lens of Tiantai's Perfect Integration of the Three Truths. It concludes with reflective and personal reflections on the research journey and final remarks paying tribute to the participants whose voices bring this work to life.

The appendices provide supplementary materials that document the research process and enhance transparency. These include a statistical summary of the questionnaire data, in vivo code lists, thematic code lists, code group summaries, the participant information sheet and informed consent forms, recruitment emails, the questionnaire instrument, and the interview questions. Taken together, these materials offer a comprehensive audit trail of the study and allow readers to assess the trustworthiness of the findings.

Definitions of key terms (see Appendix A) are provided as working definitions grounded in the scope of this project. These terms are defined to clarify how they are used in the study and to reduce conceptual ambiguity across the fields of Buddhist studies,

chaplaincy education, and qualitative research. Several terms, including spiritual care, chaplaincy, monastic, and CPE, can carry different meanings across institutional and cultural contexts.

This structure—moving from introduction through the literature review and methodology to findings, discussion, and conclusion—reflects IPA's hermeneutic commitments while keeping Buddhist monastics' voices at the center throughout. Each chapter builds on the one before it to develop a rich, nuanced account of how seven individuals have navigated the intersection of monastic vocation and clinical training—and what their experiences reveal about the possibilities and challenges of Buddhist participation in CPE.

Chapter Two:

Literature Review

CPE: History and Contemporary Developments

CPE is a distinctive pedagogical model that integrates theological education with experiential learning in clinical settings. It began in America in the early twentieth century when a small band of innovators tried to reform theological education by bringin g students into direct contact with human suffering. This section traces CPE's historical development, outlines its core methodologies, and examines how it has evolved into a multi-religious, internationally recognized form of professional training for spiritual caregivers.

Origins and Founding Vision

The history of the origin of CPE, in the traditional sense, centers on Anton T. Boisen (1876–1965), a Presbyterian minister whose own mental illness led to a groundbreaking model of pastoral training.[19] Hospitalized for psychotic episodes on multiple occasions, Boisen emerged from these experiences convinced that living human documents—individuals in crisis—offered theological insights as profound as any written text.[20] E. Brooks Holifield, a historian of pastoral care, observes that Boisen believed "the study of living human documents could provide the data for a genuine theology" and that

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[19] Sean J. LaBat, *Anton Boisen: Madness, Mysticism, and the Origins of Clinical Pastoral Education* (Lanham: Lexington, 2021).

[20] Glenn H. Asquith, "Anton T. Boisen and the Study of 'Living Human Documents,'" *JPresbyterian Historical Society* 60, no. 3 (1982): 244–65, https://www.jstor.org/stable/23328440.

"mental illness represented not simply pathology but also an attempt at self-healing, a problem-solving effort of the personality."[21]

In 1925, Boisen collaborated with physician Richard Cabot at Massachusetts's Worcester State Hospital to establish the first clinical training program for theological students. Cabot, already an advocate for clinical training in medical education, had argued in a widely read article that "the training of the theological student should include, as the training of the medical student now does, some responsible and supervised work with patients."[22] The Worcester program placed students on psychiatric wards, requiring them to observe, interact with patients, and reflect systematically on their experiences under clinical supervision.

A parallel stream of development emerged through the work of Helen Flanders Dunbar (1902–1959), a physician with graduate training in theology and psychology. Dunbar directed the Council for the Clinical Training of Theological Students, founded in 1930, which expanded clinical training beyond psychiatric settings into general hospitals and correctional institutions.[23] Her 1937 study *Emotions and Bodily Changes* helped establish the psychosomatic perspective that would inform pastoral care for decades.[24] Dunbar's insistence on rigorous standards—detailed case studies, supervised clinical

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[21] E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization* (Nashville: Abingdon Press, 1983), 244.

[22] Richard C. Cabot, "A Plea for a Clinical Year in the Course of Theological Study," in *Adventures on the Borderlands of Ethics* (New York and London: Harper & Brothers, 1926), 1.

[23] Council for Clinical Training, "Council for the Clinical Training of Theological Students records, circa 1923–1949," The Burke Library at Union Theological Seminary, Columbia University in the City of New York, accessed March 11, 2026, https://findingaids.library.columbia.edu/archives/cul-6351504.

[24] H. Flanders Dunbar, *Emotions and Bodily Changes: A Survey of Literature on Psychosomatic Interrelationships 1910–1933* (New York: Columbia University Press, 1935).

hours, and interdisciplinary collaboration—forged CPE's lasting commitment to professional accountability.

The Action-Reflection Model

At the heart of the CPE methodology is what practitioners call the "action-reflection" or "clinical pastoral" model of learning. This is based on pedagogies of experiential learning, notably the thought of John Dewey, who believed that authentic education occurs in the dialectic of doing and reflecting.[25] In the CPE context, students provide direct spiritual care to patients, families, and staff, then return to seminar rooms and supervision sessions to examine those encounters systematically.[26]

The central pedagogical tool for this reflective process is the "verbatim," a written reconstruction of a pastoral conversation that students prepare according to standardized formats. Verbatims include not only dialogue but also attention to setting, nonverbal communication, the student's internal emotional responses, and theological reflections. As CPE educator John Patton explains, the verbatim "is not primarily a report of what happened but a tool for learning. It is a way of bringing the pastoral interaction into the supervisory session so that the student can re-experience it with the supervisor and peers and learn from that re-experiencing."[27]

Group process constitutes another essential element of CPE methodology. Students meet weekly in peer groups to present verbatim, discuss ethical dilemmas, and

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[25] John Dewey, *How We Think: A Restatement of the Relation of Reflective Thinking to the Educative Process* (Boston: D.C. Heath, 1933).

[26] Gary Carr, "Understanding Clinical Pastoral Education for Chaplains," The Wesleyan Church, published October 1, 2025, https://www.wesleyan.org/understanding-clinical-pastoral-education-for-chaplains.

[27] John Patton, *Pastoral Care in Context: An Introduction to Pastoral Care* (Louisville: Westminster John Knox Press, 1993), 107.

explore their developing pastoral identities. This collaborative dimension reflects the influence of group dynamics theory on CPE's development, particularly the recognition that peer feedback and interpersonal learning accelerate professional growth in ways individual supervision alone cannot achieve.[28]

Institutionalization and Professionalization

By the mid-twentieth century, CPE had evolved from an experimental innovation into a standard professional requirement. In 1967, a number of regional training organizations united to form the Association for Clinical Pastoral Education (ACPE). ACPE sets standards for the accreditation of training centers and supervisors.[29] This consolidation happened in response to increasing demand from health care institutions for professionally trained chaplains who could function well as part of interdisciplinary teams.

The standardization process involved articulating measurable learning outcomes. Contemporary ACPE accreditation standards identify five primary competency categories: (1) Spiritual Formation and Integration: the awareness and integration of one's narrative history, socio-cultural identity, and spiritual/values-based orienting systems; (2) Awareness of Self and Others: including self-care, justice-seeking awareness of personal biases, and intercultural/interreligious humility; (3) Relational Dynamics: encompassing empathy, appropriate relational boundaries, and constructive engagement with group dynamics; (4) Spiritual Care Interventions: including the development of spiritual care relationships, the use of cultural/religious/spiritual resources, and the application of

[28] Edward E. Thornton, *Professional Education for Ministry: A History of Clinical Pastoral Education* (Nashville: Abingdon Press, 1970), 123–45.

[29] "ACPE Brief History," ACPE, accessed January 15, 2026, https://acpe.edu/docs/default-source/acpe-history/acpe-brief-history.pdf.

spiritual assessments and care plans; and (5) Professional Development: involving the clinical method of action-reflection-action learning, professional accountability and ethical practice, peer consultation, interdisciplinary teamwork, and research-informed care.[30] These competencies are assessed through demonstrated performance rather than coursework completion, reflecting CPE's enduring commitment to experiential learning.

The latter decades of the twentieth century also saw CPE's expansion beyond its original Protestant context. Roman Catholic seminaries and religious orders began requiring CPE units for ordination candidates; Jewish institutions developed parallel training programs; and by the 1990s, Buddhist, Muslim, Hindu, and humanist students were participating in CPE programs, often bringing questions about how their traditions' approaches to suffering and care might integrate with CPE's historically Christian frameworks.[31]

Contemporary Scope and Structure

Today, CPE functions as the foundational clinical training for chaplains across multiple settings. A single CPE unit typically requires 400 hours of supervised clinical practice, including at least 100 hours of structured educational sessions. Students complete multiple units, often four or more, to qualify for board certification through organizations such as the Association of Professional Chaplains (APC) or its denominational equivalents.[32]

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[30] "ACPE Outcomes and Indicators," ACPE, accessed January 15, 2026, https://www.manula.com/manuals/acpe/acpe-manuals/2016/en/topic/acpe-outcomes-and-indicators.

[31] Lucinda A. Mosher, "Toward a Pedagogy of Interfaith Chaplaincy," *Reflective Practice: Formation and Supervision in Ministry* 37 (2017): 112–25.

[32] Gauthier et al., "Path to Buddhist Chaplaincy," 228–29.

Training sites have diversified considerably since Boisen's era. While hospitals remain the most common setting, accredited CPE programs now operate in hospices, long-term care facilities, correctional institutions, military installations, congregational settings, and community organizations. This expansion reflects the recognition that the competencies developed through CPE—self-awareness, interpersonal effectiveness, theological reflection, and emotional resilience—are valuable across the full range of pastoral ministry.

Another major trend is the global expansion of CPE. Across North America, Europe, Asia, Africa, and Australia, these programs typically modify their core approaches to align with local cultural and religious contexts.[33] In some cases, this adaptation has raised fundamental questions about whether CPE's underlying assumptions—especially its emphasis on verbally expressing emotions and its expectation that students engage in deep self-disclosure—remain appropriate across cultural boundaries.[34]

Buddhist Chaplaincy: Emergence and Current Landscape

The emergence of Buddhist chaplaincy as a recognized profession represents an important step in the history of Buddhist practice. While Buddhists have cared for the sick, dying, and distressed since the time of the Buddha, the formalization of Buddhist

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[33] Daniel J. Louw, "The Hermeneutics of Intercultural Pastoral Care: From 'psyche' to 'Position' (Habitus) within the Healing Dynamics of Life (Cura Vitae)," *Scriptura: Journal for Contextual Hermeneutics in Southern Africa* 103, no. 1 (2010): 175–88, https://doi.org/10.10520/EJC100519.

[34] For discussion of cross-cultural adaptation, see Emmanuel Y. Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*, 2nd ed. (London: Jessica Kingsley Publishers, 2003).

spiritual care within secular institutions—hospitals, prisons, universities, and military units—is largely a twenty-first-century phenomenon. This section explores the historical context of Buddhist caregiving, the current institutionalization of Buddhist chaplaincy, and the distinctive features that set Buddhist approaches to spiritual care apart.

Historical Backgrounds in the Buddhist Tradition

The Buddhist scriptural canon contains a wealth of passages declaring the care of the sick to be an essential obligation for monastic practitioners. In the Mahāvagga of the Pāli Canon, the Buddha explicitly instructs monastics to care for ill fellow monastics, saying: "Whoever would tend to me, should tend to the sick."[35] This order became a precedent for Buddhist communities over the centuries and across cultures. The monastic infirmary was a place of medical and spiritual healing in all ancient Indian, Sri Lankan, Chinese, and Tibetan monasteries. These places were often open to laypeople, not just monastics.

Buddhaghosa's fifth-century compendium of Theravāda practice, the *Visuddhimagga*, contains detailed instructions on caring for the sick and emphasizes the cultivation of loving-kindness (*mettā*) and compassion (*karuṇā*) as the essential qualities of those who tend the suffering.[36] Similarly, the Mahāyāna *Vimalakīrti Sūtra* presents the lay bodhisattva Vimalakīrti teaching that the bodhisattva's very presence heals by revealing the nature of suffering and the path to liberation, a perspective that resonates

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[35] Thanissaro Bhikkhu, trans, "Kucchivikara-vatthu: The Monk with Dysentery (Mv 8.26.1-8)," Access to Insight (BCBS Edition), last modified 30 November 2013, http://www.accesstoinsight.org/tipitaka/vin/mv/mv.08.26.01-08.than.html.

[36] Buddhaghosa, *Visuddhimagga*, chapter IX, translated by Ñāṇamoli Bhikkhu (Seattle: BPS Pariyatti Editions, 1999).

with contemporary understandings of chaplaincy as offering presence rather than intervention.[37]

Despite these historical antecedents, the term "chaplain" has no direct equivalent in classical Buddhist languages. As Sri Lankan Theravāda monk Bhante Kusala notes in his reflection on training at Harvard Divinity School, proposed Pāli translations such as *puggalika devaṭṭhānādhikārika* (a personal clergy member who connects with the divine) prove inadequate because "this interpretation does not make any sense in Buddhism because there is no 'divine' to connect to."[38] Kusala and his teacher Charles Hallisey have suggested alternative formulations: *paradukkha seviya* (one who searches for others who suffer), *paradukkha sevaka* (one who serves those who suffer), or *ajjhattika sahāyaka* (spiritual supporter). These linguistic negotiations reflect the broader challenge of translating a Christian-institutional category into Buddhist terms while preserving what is distinctive about Buddhist approaches to suffering and care.

The Contemporary Emergence of Buddhist Chaplaincy

As scholars Sanford and Michon observe in their comprehensive overview of the field, "Although the roots of spiritual care date back to the beginning of the Buddhist traditions, professionalized Buddhist chaplaincy is a very recent phenomenon. Despite some beginnings in the mid-20th century, most developments have occurred rapidly only within the 21st century."[39] This rapid emergence reflects multiple converging factors.

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[37] Burton Watson, trans., *The Vimalakīrti Sūtra* (New York: Columbia University Press, 1997).

[38] Kusala, "Can a Buddhist Monk."

[39] Monica Sanford and Nathan Jishin Michon, "Buddhist Chaplaincy," in *Oxford Research Encyclopedia of Religion*, ed. John Barton (New York: Oxford University Press, 2019), https://doi.org/10.1093/acrefore/9780199340378.013.641.

First, the expansion of professional chaplaincy beyond its Christian origins created institutional space for non-Christian practitioners.[40] In the United States, the 1985 U.S. Supreme Court decision in *Wallace v. Jaffree*, which addressed questions of religious establishment in public institutions, indirectly accelerated the diversification of chaplaincy by emphasizing the state's interest in accommodating diverse religious needs.[41] Healthcare and correctional institutions increasingly recognized that serving religiously diverse populations required chaplains representing those populations.

Second, Buddhist communities in diaspora—particularly in North America and Europe—produced generations of practitioners fluent in both Buddhist teachings and Western institutional cultures. These practitioners increasingly sought vocational pathways that would allow them to apply Buddhist wisdom in service to broader society. Graduate programs in Buddhist chaplaincy emerged to meet this need: the University of the West's Master of Divinity in Buddhist Chaplaincy (founded 2009), the Institute of Buddhist Studies' Master of Divinity with a specialization in Buddhist Chaplaincy (founded 2009), and Naropa University's Master of Divinity program (founded 2001) represent early efforts to create structured educational pathways.

Third, existing certifying agencies for chaplaincy began to alter requirements to accommodate the needs of Buddhist applicants. The APC, through its Board of Chaplaincy Certification Inc. (BCCI), developed formal mechanisms to address the structural differences in Buddhist traditions. Specifically, the BCCI created a formal

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[40] Danny Fisher, "Benefit Beings!: The Buddhist Guide to Professional Chaplaincy" (PhD diss., University of the West, 2013).

[41] "Wallace v. Jaffree, 472 U.S. 38 (1985)," Justia, accessed March 11, 2026, https://supreme.justia.com/cases/federal/us/472/38/. On chaplaincy implications, see Winnifred Fallers Sullivan, *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: University of Chicago Press, 2014), 67–89.

pathway for Buddhists to demonstrate graduate-level theological education through an equivalency process, as outlined in a foundational 2006 document commonly referred to as the "Buddhist White Paper."[42] This process allows applicants from Buddhist traditions, which often lack the hierarchical structures of Western denominations, to document their years of practice and study to meet the 72-credit graduate degree requirement for board certification. Furthermore, the BCCI's certification manual explicitly provides for evaluating "Spiritual/Faith groups that use mentored education" using the framework found in this Buddhist White Paper, thereby creating an endorsement procedure that respects non-hierarchical models while ensuring accountability.[43]

Similarly, the ACPE accredits Buddhist-affiliated CPE centers. For instance, the New York Zen Center for Contemplative Care is recognized as a unique provider, being "the only Zen Buddhist-based organization accredited by the ACPE to offer CPE for those pursuing professional chaplaincy."[44] Additionally, Naropa University's Center for Contemplative Chaplaincy, which offers "Buddhist-inspired contemplative spiritual health training," was granted full accreditation as a CPE program by ACPE in the Fall of 2023.[45] These accredited centers enable Buddhist students to complete their required clinical training in settings where their tradition's contemplative practices and perspectives directly inform their supervision and spiritual care formation. This

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[42] "SZI Professional Chaplain-Specific FAQs," Shogaku Zen Institute, accessed March 11, 2026, https://www.shogakuzen.org/chaplaincyspecific-faqs.

[43] "BCCI Certification Manual," Association of Professional Chaplains, accessed March 11, 2026, www.apchaplains.org/bcci-site/about-bcci/bcci-certification-manual/.

[44] "About Us," New York Zen Center for Contemplative Care, accessed March 11, 2026, https://zencare.org/about-us.

[45] "Center for Contemplative Chaplaincy," Naropa University, accessed March 11, 2026, https://www.naropa.edu/programs/graduate-academics/divinity/center-for-contemplative-chaplaincy/.

integration ensures that students' learning is grounded in their own tradition while meeting the rigorous, interfaith professional standards required for board certification.

Contemporary Buddhist Chaplaincy Across Contexts

The landscape of contemporary Buddhist chaplaincy varies across geographical and institutional contexts. In North America, Buddhist chaplains work in hospitals, hospices, colleges and universities, prisons, and the military. They often collaborate in multifaith departments with chaplains of other religious traditions. Their training typically includes graduate-level theological education, multiple units of CPE, and endorsement from a Buddhist community or teacher.[46] Many also hold board certification from organizations such as the APC, which has developed formal pathways to support Buddhist applicants by recognizing the non-hierarchical nature of many Buddhist spiritual communities.[47]

European Buddhist chaplaincy has developed somewhat differently, reflecting Europe's distinct religious demographics and healthcare structures. In the United Kingdom, the Network of Buddhist Organisations maintains a register of Buddhist chaplains,[48] and the NHS Chaplaincy Guidelines explicitly acknowledge that chaplains from a particular religion or belief group may also deliver religious or belief-specific care

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[46] Henry C. H. Shiu, "The Emergence of Buddhist Chaplaincy Training in Ontario, Canada," *Canadian Journal of Buddhist Studies* 17 (2022).

[47] See "BCCI Certification Manual," and Monica Sanford et al., *Mapping Buddhist Chaplains in North America* (Waltham: Chaplaincy Innovation Lab, 2022), https://chaplaincyinnovation.org/resources/ebooks/mapping-buddhist-chaplains.

[48] "Chaplaincy," *Network of Buddhist Organisations*, accessed March 12, 2026, https://www.nbo.org.uk/resources/chaplaincy/.

for service users who seek their support.[49] In Germany, where chaplaincy is still more closely tied to the established churches, Buddhist practitioners have only recently begun to gain access to institutional positions, often through legal challenges based on principles of religious nondiscrimination.[50]

Despite the potential for different social dynamics in Buddhist-majority populations in Asia, professional chaplaincy remains a Western import that adapts to local conditions.[51] Japanese universities now offer chaplaincy training programs that integrate CPE methodology with Japanese Buddhist and cultural sensibilities. Ryukoku University established a "*Rinsho-shukyo-shi*" (clinical religious scholar) training program in 2014, which specifically incorporates CPE methods while training Buddhist practitioners to provide spiritual care in hospitals and elderly care facilities.[52] This program emphasizes group work and experiential learning about "self-knowledge" and "self-acceptance" within a Buddhist framework.[53] The introduction of chaplaincy to

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[49] "NHS Chaplaincy – Guidelines for NHS Managers on Pastoral, Spiritual and Religious Care," NHS England, last modified August 14, 2023, https://www.england.nhs.uk/long-read/nhs-chaplaincy-guidelines-for-nhs-managers-on-pastoral-spiritual-and-religious-care/.

[50] On German developments, see Aysun Tekbaş et al., "Intersection of Religious Beliefs and Healthcare in Germany: A Guide to Integrating Religious Diversity in Medical Practice," *Cureus* 17, no. 4 (2025): e82932, https://doi.org/10.7759/cureus.82932.

[51] Yozo Taniyama, "The Vihāra Movement: Buddhist Chaplaincy and Social Welfare in Japan," in *Buddhist Care for the Dying and Bereaved*, ed. Jonathan S. Watts and Yoshiharu Tomatsu (Boston: Wisdom Publications, 2012), 75–94.

[52] Kōyū Uchimoto, "Training of Buddhists to Deal with the Patients: A Case at Ryukoku University's 'Practical Training program for Interfaith Chaplains,'" *The Journal of the Nippon Buddhist Research Association* 88 (2024): 103–30, https://doi.org/10.15033/nbra.88.0__103_.

[53] Uchimoto, "Training of Buddhists."

Japan is a major example of the acceptance of religious practice in public space and challenges traditional Japanese understandings of the separation of religion and state.[54]

Thai hospitals and healthcare institutions are increasingly incorporating Buddhist spiritual care providers who draw on Theravāda teachings while working within institutional frameworks shaped by international healthcare standards. The Arokhayasala Khampramong temple in Sakon Nakhon Province is widely recognized as a model palliative care center. It provides end-of-life care that combines traditional and modern medicine along with spiritual support such as meditation, evening prayers, and religious counseling.[55] This facility has partnered with Thailand's National Health Security Office and is registered as a palliative care unit under the Universal Coverage Scheme, which enables reimbursement for the services it provides.[56] In addition, Chulalongkorn Memorial Hospital in Bangkok has a Department of Ceremony that specifically organizes religious services and offers spiritual support to patients and their families. It also provides Buddhist teachings for hospital staff.[57] More recently, hospitals in Bangkok have opened specialized inpatient units for sick monks that integrate spiritual and

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[54] Kasai Kenta, "Introducing Chaplaincy to Japanese Society: A Religious Practice in Public Space," *Journal of Religion in Japan* 5, no. 2–3 (2016): 246–62, https://doi.org/10.1163/22118349-00502009.

[55] "NHSO to Partner with Arokhayasala Khampramong Temple in delivering palliative care," National Health Security Office, published February 16, 2024, https://eng.nhso.go.th/view/1/DescriptionNews/NHSO-to-partner-with-Arokhayasala-Khampramong-Temple-in-delivering-palliative-care/596/EN-US.

[56] "NHSO to Partner with."

[57] "Department of Ceremony," King Chulalongkorn Memorial Hospital, accessed March 12, 2026, https://kcmh.chulalongkornhospital.go.th/en/dept/department-of-ceremony-en/.

physical healing, including Dhamma pavilions where monks can perform merit-making rituals while receiving medical treatment.[58]

These Asian developments are especially important in that they challenge assumptions that chaplaincy is merely the export of Western Christian models. Rather, they suggest a more complex process of mutual adaptation and reinterpretation.[59] It has been suggested that "while Western hospice care, based on the life structure of the body, mind, and soul as conceived of in Christianity, focuses on the spiritual care of the patient, Buddhists may concentrate on the four establishments of mindfulness regarding the body, feelings, states of mind, and phenomena, or focus on the life structure of the body, mind, and wisdom."[60] Academic observers have noted that across Asia, Buddhists are "stepping forward to build standards for providing spiritual care in the context of cultural institutions that are not typically religious (e.g., hospitals and schools)."[61] International conferences have brought together scholars and practitioners from China, Japan, and the United States to discuss how Buddhist chaplaincy serves as an example of how Buddhism is adapting to modern society in different cultural contexts.[62]

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[58] "Bangkok's New Approach to Monk Healthcare: Where Medicine Meets Tradition," Bangkok Public Relations, published February 22, 2025, https://pr-bangkok.com/?p=468648.

[59] Michael Berman, "Religion Overcoming Religions: Suffering, Secularism, and the Training of Interfaith Chaplains in Japan," *American Ethnologist* 45, no. 2 (2018): 228–40, https://doi.org/10.1111/amet.12634.

[60] Ching-Yu Chen, "Clinical Buddhist Chaplain-Based Spiritual Care in Taiwan," *Taiwan Journal of Hospice Palliative Care* 17, no. 3 (2013): 300–309.

[61] Sanford and Michon, "Buddhist Chaplaincy."

[62] Justin Whitaker, "Columbia University Hosts Buddhist Chaplaincy Conference in New York," Buddhistdoor Global, published May 7, 2019, https://www.buddhistdoor.net/news/columbia-university-hosts-buddhist-chaplaincy-conference-in-new-york.

Distinctive Features of Buddhist Spiritual Care

While Buddhist chaplains perform many functions common to all chaplains—assessing spiritual needs, providing emotional support, offering ritual care—scholars and practitioners have identified distinctive features of Buddhist approaches to spiritual care.[63] Sanford and Michon note that "Buddhist spiritual care may be distinct in its theory (Dharma based) and place more emphasis on mindfulness, meditation, and other contemplative techniques to benefit both careseekers and chaplains."[64]

The concept of "Dharma-based" care merits examination. For Buddhist chaplains, the Dharma—the Buddha's teachings on suffering, its causes, and the path to liberation—provides both the interpretative framework for understanding suffering and the practical resources for responding to it. The Four Noble Truths, for instance, offer a diagnostic structure: acknowledging suffering (first truth), identifying its causes in attachment and aversion (second truth), recognizing that liberation is possible (third truth), and following the Eightfold Path (fourth truth).[65] This framework guides Buddhist chaplains' understanding of their role, not in solving problems, but in assisting careseekers to relate to their experience wisely.

A second special dimension is mindfulness practice. Many Buddhist chaplains maintain personal meditation practice as foundational to their capacity to offer presence

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[63] Michael Monnet, "Developing a Buddhist Approach to Pastoral Care," in *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*, ed. Cheryl A. Giles and Willa B. Miller (New York: Oxford University Press, 2015), 231–46.

[64] Sanford and Michon, "Buddhist Chaplaincy."

[65] Piyadassi Thera, trans., "Dhammacakkappavattana Sutta: Setting in Motion the Wheel of Truth (SN 56.11)," Access to Insight (BCBS Edition), last modified November 30, 2013, https://www.accesstoinsight.org/tipitaka/sn/sn56/sn56.011.piya.html; for recent related studies, see Seong Hui Bark, "Buddhist Chaplain Role in Hospitals: Exploring Spiritual Care Through Storytelling Using the Framework of the Four Noble Truths" (DBMin. diss., University of the West, 2024).

to sufferers.[66] This practice cultivates what Tibetan Buddhists call "ordinary mind"—awareness free from grasping and aversion—that enables chaplains to remain present with intense suffering without withdrawing defensively or imposing their own agendas.[67] Some Buddhist chaplains also offer mindfulness instruction to careseekers as a coping resource, though typically with careful attention to whether such instruction is appropriate for those in acute distress.

Ritual proficiency represents a third distinctive feature. Buddhist chaplains must be competent to perform rituals appropriate to various Buddhist traditions: chanting *suttas* for Theravāda patients, offering *nembutsu* (the practice of reciting the name of Amitabha Buddha) for Pure Land practitioners, and leading Chan (禪, Zen) meditation for those from that lineage. Given the diversity of Buddhist practice, this requirement creates significant challenges for Buddhist chaplains, who cannot be experts in all traditions and must therefore develop skills in assessing patients' ritual needs and, when necessary, connecting them with appropriate co-religionist practitioners.

Humanistic Buddhism and Its Institutional Embodiment

Humanistic Buddhism (*renjian fojiao* 人間佛教) represents a major reform movement within modern Chinese Buddhism that has profoundly reshaped how Buddhist monastics understand their role in society. This section examines the history of Humanistic Buddhism, its main philosophical ideas, its growth as an institution in

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[66] Nyanasatta Thera, trans., "Satipatthana Sutta: The Foundations of Mindfulness (MN 10)," Access to Insight (BCBS Edition), last modified December 1, 2013, https://www.accesstoinsight.org/tipitaka/mn/mn.010.nysa.html.

[67] On "ordinary mind" in Tibetan Buddhism, see Chögyam Trungpa, *The Myth of Freedom and the Way of Meditation* (Berkeley: Shambhala, 1976), 34–45.

modern times, the role of monks within its ideological context, and its increasing importance for Buddhist spiritual care and chaplaincy. Understanding Humanistic Buddhism is important for this study because many Buddhist monastics who enter CPE in the United States have been trained in institutions influenced by this movement and come with its particular orientation toward compassionate social engagement.

Historical Roots and Core Principles

Humanistic Buddhism is a reform movement that emerged in early twentieth-century China and intended to refocus Buddhist practice away from what its advocates saw as an overemphasis on death rituals, otherworldly concerns, and monastic withdrawal from society.[68] The term is most closely associated with Venerable Tai Xu (太虛, 1890–1947), a monk who witnessed Buddhism's decline under the pressures of modernization, secularization, and competition from Christian missionaries. Tai Xu advocated for what he initially called "Buddhism for Human Life" (*rensheng fojiao* 人生佛教), emphasizing the improvement of real-life conditions as the foundation for Buddhist practice. He proposed that Buddhist cultivation must be integrated into daily living rather than pursued solely through withdrawal from the world.[69] According to Darui Long, Tai Xu's approach aimed to "revitalize Buddhism in the difficult situation for survival" by integrating Buddhist principles with Chinese tradition and emphasizing

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[68] Yushuang Yao and Richard F. Gombrich, *Chinese Buddhism Today: Conservatism, Modernism, Syncretism and Enjoying Life on the Buddha's Light Mountain* (Sheffield: Equinox Publishing, 2022), 1–11.

[69] On Tai Xu and the origins of Humanistic Buddhism, see Don A. Pittman, *Toward a Modern Chinese Buddhism: Taixu's Reforms* (Honolulu: University of Hawai'i Press, 2001); and Yao and Gombrich, *Chinese Buddhism Today*, 1–11.

"Buddhist contributions to family, society, state, and religion itself, thus pulling Chinese Buddhism back onto earth."[70]

Tai Xu's disciple, Venerable Yin Shun (印順, 1906–2005), further refined the concept, preferring the term "Humanistic Buddhism" (*renjian fojiao* 人間佛教) to distinguish his approach from what he saw as the "deification" of Buddhism in much contemporary Chinese practice.[71] Yin Shun articulated six core principles that continue to inform Humanistic Buddhist movements: humanism, altruism, spiritual practices integrated into daily life, joyfulness, timeliness (adapting to contemporary conditions), and the universality of saving all beings.[72] These principles collectively reject the notion that Buddhist practice is primarily about personal cultivation or otherworldly escape, instead affirming that genuine Dharma practice must address the concrete suffering of human beings in this world.

Scholars have identified several interconnected principles that characterize Humanistic Buddhist thought and practice. As one analysis summarizes, Humanistic Buddhism is said to aim at a *chushi* 出世 approach (a spiritual and otherworldly attitude) toward a *rushi* 入世 practice (a practice focused on problems and questions of the

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[70] Darui Long, "Ethics in Humanistic Buddhism: Studies on Venerable Taixu and Master Hsing Yun's Views on Ethics," *Hsi Lai Journal of Humanistic Buddhism* 3 (2002): 333–51, https://ir.uwest.edu/s/index/item/424.

[71] Yin Shun, *The Way to Buddhahood: Instructions from a Modern Chinese Master*, trans. Wing H. Yeung (Boston: Wisdom Publications, 1998), 8–10.

[72] Xu Baofeng, ed., "Humanistic Buddhism (人間佛教)," in *Contextual Dictionary of Chinese Cultural Knowledge* (Singapore: Springer Nature, 2025), https://doi.org/10.1007/978-981-99-5009-6_10165.

contemporary and actual human world).[73] This dialectical relationship between transcendence and engagement constitutes the movement's distinctive contribution to Buddhist thought.

The principle of *qiji* 契機 (transforming according to the situation) provides a hermeneutical model for the translation of Buddhist teachings into modern conditions while maintaining *qili* 契理 (core principles) and without losing their essential content.[74] This principle has enabled Humanistic Buddhist organizations to engage with modern institutions—hospitals, schools, universities, and social service agencies—while maintaining distinctively Buddhist practices and perspectives. It has also informed their responses to modern values such as gender equality, environmental protection, and human rights.

Central to Humanistic Buddhist thought is the bodhisattva ideal, understood as social engagement rather than merely aspirational compassion. According to Venerable Master Hsing Yun (星雲, 1927–2023), who further developed Humanistic Buddhism in the late twentieth century, the tradition's primary goal is "to lead to the Bodhisattva practice, i.e., to be an energetic, enlightened, and endearing person who strives to help sentient beings liberate themselves."[75] This emphasis on active, compassionate action in the world—rather than passive withdrawal or ritual observance—would prove

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[73] Stefania Travagnin, "Humanistic Buddhism (Rensheng Fojiao 人生佛教 / Renjian Fojiao 人間佛教)," in *Oxford Research Encyclopedia of Religion*, ed. John Barton (New York: Oxford University Press, 2022), https://doi.org/10.1093/acrefore/9780199340378.013.635.

[74] Travagnin, "Humanistic Buddhism."

[75] Shanker Thapa, "Master Hsing Yun of Fo Guang Shan and the Development of Humanistic Buddhism," in *Taiwan Today*, ed. Anita Sharma and Sreemati Chakrabarti (London: Anthem Press, 2010), 207.

foundational to the development of Buddhist chaplaincy and spiritual care training in Humanistic Buddhist institutions.

Contemporary Institutionalization

Originating in the reforms initiated by Tai Xu in the early twentieth century and further developed by Yin Shun in postwar Taiwan, the movement gave rise to major institutional expressions, including Fo Guang Shan, Tzu Chi, Dharma Drum Mountain, and Chung Tai Shan.[76] Fo Guang Shan, founded by Venerable Master Hsing Yun, has since become one of the most influential Humanistic Buddhist organizations globally. Hsing Yun encountered Tai Xu shortly before the elder master's passing. After relocating from mainland China to Taiwan in 1949, he founded his own Humanistic Buddhist movement, which eventually grew into a worldwide monastic order with branches in nearly two hundred countries.[77] Hsing Yun's distinctive contribution was to encourage Buddhists to enjoy life utilizing the tools and products of modern life and the building of a Pure Land-like world in this life, rather than focusing solely on rebirth in the Pure Land after death.[78] Under his leadership, Fo Guang Shan developed extensive educational, cultural, and charitable programs that exemplify Humanistic Buddhist principles in practice.

The institutionalization of Humanistic Buddhist education in the United States reached a significant milestone with the founding of what is now the University of the

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[76] On Tzu Chi, Dharma Drum Mountain, and Chung Tai Shan, see Yao and Gombrich, *Chinese Buddhism Today*, 1–11.

[77] On Venerable Master Hsing Yun and Fo Guang Shan, see Venerable Master Hsing Yun, *Humanistic Buddhism: A Blueprint for Life* (Los Angeles: Buddha's Light Publishing, 2008); and Venerable Master Hsing Yun, *For All Living Beings: A Guide to Buddhist Practice* (Los Angeles: Buddha's Light Publishing, 2010).

[78] Yao and Gombrich, *Chinese Buddhism Today*, 54.

West (UWest) in Rosemead, California. Established in 1991 by Venerable Master Hsing Yun, the university represents the Master's deep commitment to education as one of the important means of propagating Buddhism and serving society.

The university's mission statement reflects its grounding in Humanistic Buddhist values: "Embracing the timeless values of Humanistic Buddhism, UWest offers an education that is as much about personal growth as it is about academic excellence. Our mission is to empower students to lead lives of purpose, integrity, and compassion."[79] This mission reflects key Humanistic Buddhist principles—compassion as active engagement with human suffering, the integration of study and practice, and education understood not merely as knowledge acquisition but as cultivation of the whole person. The university's strategic plan further reaffirms "the university's Buddhist identity and solidifying its standing in the landscape of American higher education."[80] This explicit maintenance of a Buddhist institutional identity while operating within the structures of American secular higher education exemplifies the kind of boundary negotiation that characterizes Humanistic Buddhist adaptation to Western contexts.

The Buddhist Chaplaincy program at UWest represents a significant institutional development at the intersection of Humanistic Buddhist education and professional spiritual care training. The program was formally approved by the Western Association of Schools and Colleges (WASC) in 2008, making UWest one of only three American

[79] "About UWest," University of the West, accessed March 11, 2026, https://www.uwest.edu/about-uwest/.

[80] "Strategic Plan," University of the West, accessed March 11, 2026, https://www.uwest.edu/about-strategic-plan/.

schools at that time offering an accredited Buddhist chaplaincy program.[81] Graduates from UWest's Buddhist Chaplaincy programs may take on various professional roles, serving as chaplains in healthcare facilities, the military, prisons, and universities, as well as serving as community spiritual leaders.

What distinguishes UWest's chaplaincy training from purely secular or Christian-influenced programs is its immersion in a living Buddhist monastic community. As the program description highlights, what makes this program unique is:

> UWest's MDiv in Buddhist Chaplaincy offers more than academic study, it's a full immersion into the practice of spiritual care rooted in Buddhist values. Students engage in group process work, service learning, and clinical internships every semester, developing skills in pastoral counseling, interfaith ritual, and nonprofit leadership. The program fulfills all nine APC core competencies, preparing graduates for professional chaplaincy certification. With direct access to Hsi Lai Temple, the North American headquarters of Fo Guang Shan, students train alongside a living Buddhist community, deepening their spiritual formation and gaining practical experience in diverse care settings—from hospitals and hospices to prisons, universities, and the military.[82]

UWest's MDiv program is affiliated with Fo Guang Shan, a global Buddhist monastic order dedicated to Humanistic and Engaged Buddhism. It is near the Hsi Lai Temple, which offers a work-study model combining academic learning with direct experience in Buddhist spiritual care.[83] This integration of academic coursework with temple-based practice reflects the Humanistic Buddhist educational philosophy of combining study with lived experience.

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[81] "WASC Approves New University of the West Buddhist Chaplaincy Program," Pluralism Project Archive, published August 14, 2008, https://pluralismarchive.hsites.harvard.edu/news/wasc-approves-new-university-west-buddhist-chaplaincy-program.

[82] "Master of Divinity in Buddhist Chaplaincy (MDiv)," University of the West, accessed March 11, 2026, https://www.uwest.edu/mdiv-masters-of-divinity/.

[83] "Master of Divinity."

Significantly for the present study, UWest's chaplaincy program was developed in collaboration with hospital-based CPE programs. As officially stated, "The development of the interfaith Master of Divinity program at UWest is the product of intense collaboration with hospital-based clinical pastoral education programs, Christian and Buddhist denominations, and eminent theologians from the United States and abroad."[84] This collaborative history suggests that UWest has positioned its chaplaincy training squarely within the professional CPE framework while adapting it to Buddhist contexts. The program encourages students to complete CPE training as "a required step for many professional chaplaincy careers."[85]

Monastic Vocation in Humanistic Buddhism

The relationship between Humanistic Buddhism and traditional monasticism has been complex and sometimes contested. Critics within more traditional Buddhist circles have charged that Humanistic Buddhism secularizes the monastic vocation, diluting the otherworldly orientation that has historically defined renunciation. Proponents respond that Humanistic Buddhism preserves discipline (Vinaya), scriptural study, and traditional practices while integrating them into daily life and service.[86] The question is not whether monastics should practice, but how and toward what end.

For monastics trained in Humanistic Buddhist institutions, the entry into CPE represents an extension rather than a departure from their formation. Humanistic Buddhism insists that Buddhist practice must address actual human suffering in real contexts, providing theological justification for the chaplain's work of presence with the

[84] "WASC Approves."
[85] "Buddhist Chaplaincy Graduate Programs."
[86] Lewis R. Lancaster, "Ethics and Humanistic Buddhism," *Hsi Lai Journal of Humanistic Buddhism* 2 (2001): 31–38.

sick, the dying, the imprisoned, and the distressed. The bodhisattva ideal—the vow to attain enlightenment for the sake of all beings—functions as a model for compassionate engagement that refuses any ultimate distinction between personal liberation and collective well-being. This understanding of practice aligns closely with the self-understanding of many chaplains, regardless of tradition, while also providing distinctively Buddhist resources for sustaining the work.

The focus on daily life as a spiritual practice is particularly apparent in contrast to the traditional monastic Buddhism in China, which has so often stressed specialized rituals and withdrawal from worldly affairs. Humanistic Buddhism teaches that any activity, working, eating, caring for others, or engaging in community life, can become a form of spiritual cultivation if done with mindful awareness and the right intention. This perspective aligns closely with CPE's action-reflection method, which similarly holds that learning arises through engagement with real human situations, not through theory alone.

The global spread of Humanistic Buddhism has significant implications for the present study, as many Buddhist monastics who enter CPE in the United States have been trained in Humanistic Buddhist institutions and bring this movement's distinctive orientation to their clinical training. Introducing Humanistic Buddhism to the West raises questions about the translation of its principles across cultural and religious boundaries, and these processes of migration and adaptation offer relevant precedents for understanding how Buddhist monastics navigate CPE in the United States. Monastics who enter CPE may discover themselves in institutional frameworks based on different assumptions than those of their training in Buddhist teachings and practices. The capacity

to translate Buddhist concepts into terms intelligible within new contexts may prove valuable for monastics navigating the boundary between Buddhist tradition and clinical training.

Summary and Relevance to the Present Study

As a dynamic and reform-oriented Buddhist movement, Humanistic Buddhism is dedicated to integrating the Buddha's teachings into daily life and addressing the practical needs and real-world challenges of human society. This movement represents a fusion of Buddhist transcendence with everyday life issues, serving as a path to realization. Its main ideas offer both religious and practical help for Buddhists working in chaplaincy and spiritual care by mixing deep spiritual understanding with everyday actions, adjusting to various situations while keeping essential teachings, and seeing daily life as a way to practice spirituality.

In recent years, scholars have begun to pay closer attention to the relevance of Humanistic Buddhism to chaplaincy and spiritual care. A 2014 study by Tsai Chang-Hsiung examining hospice care and Buddhist chaplaincy in Taiwan explicitly frames its investigation as "an example of Humanistic Buddhism in practice," arguing that the practices of Buddhist chaplains "further emphasize the significance of practice within contemporary society" and offer "worthwhile consideration in development and implementation for the future of Humanistic Buddhism."[87] This framing suggests that chaplaincy—the provision of spiritual care in institutional settings—represents not

[87] Tsai Chang-Hsiung, "Humanistic Buddhism in Practice Hospice Care and Buddhist Chaplaincy in Taiwan," in *Studies on Humanistic Buddhism: Theory and Practice of Venerable Master Hsing Yun* (Kaohsiung: Fo Guang Culture Enterprise, 2014), 420–21.

merely an occupational choice for Buddhist monastics but a concrete instantiation of Humanistic Buddhist principles.

For the present study of Buddhist monastics' lived experience in CPE, Humanistic Buddhism is relevant in several respects. First, many Buddhist monastics who pursue CPE in the United States have been trained in Humanistic Buddhist institutions and bring this movement's orientation toward compassionate social engagement to their clinical training. Second, Humanistic Buddhism's emphasis on institutional presence and professional service provides a framework for understanding why monastics might pursue chaplaincy as a vocational path. Third, the movement's resources for translating Buddhist concepts into new contexts may shape how monastics navigate the boundary between monastic formation and CPE methodology. Fourth, the scholarly debates about Humanistic Buddhism's relationship to Engaged Buddhism and to Western categories of analysis highlight the importance of attending to how participants themselves understand and articulate their practice—a concern that aligns closely with the interpretative phenomenological approach of this study.

Engaged Buddhism and Socially Engaged Practice

The development of Buddhist chaplaincy is happening alongside, and is informed by, the larger movement of Engaged Buddhism. The term was popularized by Vietnamese Zen Master Thich Nhat Hanh during the Vietnam War, and it refers to the practice of applying Buddhist teachings and practices to social, political, and environmental issues. Although Engaged Buddhism involves activism and social transformation, its commitment to compassionate action in response to suffering directly

informs Buddhist chaplaincy's understanding of practice. This section will discuss the history and development, key figures, and core principles of Engaged Buddhism, and its relationship to Buddhist Chaplaincy.

History and Development

Asian Buddhists responded to colonialism and modernization in the late nineteenth and early twentieth centuries, giving rise to Engaged Buddhism. A Sri Lankan reformer, Anagārika Dharmapāla (1864–1933) articulated a vision of Buddhism as a rational, socially engaged tradition in accord with scientific modernity, partly to rebut the claims of Christian missionaries that Buddhism fostered passivity and detachment from worldly affairs.[88] Similarly, the Burmese lay reformer U Dhammaloka (1856–1914) challenged the colonial authorities and Christian missionaries by arguing that Buddhist identity had to be actively defended against Western domination.[89] These early figures established precedents for Buddhists to publicly engage with social and political issues.

The term "Engaged Buddhism" (Vietnamese: *Đạo Phật Đi Vào Cuộc Đời*, literally meaning "Buddhism Entering into Society") was coined specifically from Thich Nhat Hanh's reaction to the Vietnam War. In 1964, Nhat Hanh and others founded the School of Youth for Social Service, a grassroots relief organization that trained young volunteers to rebuild bombed villages, set up medical clinics and help refugees—all while maintaining Buddhist contemplative practice.[90] In his 1967 book *Vietnam: Lotus in a Sea of Fire*, Nhat Hanh articulated the theological foundation of the Engaged Buddhist

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[88] Ananda Wickremeratne, *The Genesis of an Orientalist: Thomas William Rhys Davids and Buddhism in Sri Lanka* (Delhi: Motilal Banarsidass, 1984), 145–67.

[89] Alicia Turner, Saving Buddhism: *The Impermanence of Religion in Colonial Burma* (Honolulu: University of Hawai'i Press, 2014), 89–112.

[90] Chân Không, *Learning True Love: How I Learned and Practiced Social Change in Vietnam* (Berkeley: Parallax Press, 1993).

movement, contending that the bodhisattva ideal demands active engagement with the world's suffering rather than withdrawal from it.[91]

The movement gained international visibility through Nhat Hanh's relationship with Martin Luther King, Jr., who nominated him for the Nobel Peace Prize in 1967.[92] Nhat Hanh's engaged practice resonated with King's vision of the "Beloved Community"—a society grounded in justice, inclusion, and compassion—thereby linking Engaged Buddhism to Western social justice movements.[93]

Key Figures and Networks

The Thai social critic and activist Sulak Sivaraksa (b. 1933) has been a major figure in the creation of the institutional infrastructure of Engaged Buddhism. In 1989, he founded the International Network of Engaged Buddhists (INEB), which brings together Buddhist activists, scholars, and practitioners across national and sectarian boundaries.[94] Sulak's prolific writings critique consumerism, militarism, and environmental destruction from a Buddhist perspective, arguing from the Buddha's teaching on dependent origination that systemic suffering requires a systemic response. As he writes, "Buddhism teaches us that we are interdependent with all that is. Therefore, when others suffer, we suffer. When the forests are destroyed, we are diminished."[95]

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[91] Nhat Hanh, *Vietnam: Lotus in a Sea of Fire* (New York: Hill and Wang, 1967).

[92] See Martin Luther King, Jr., "Letter from Dr. Martin Luther King, Jr. Nominating Thich Nhat Hanh for the Nobel Peace Prize in 1967," January 25, 1967, Plum Village, accessed April 23, 2026, https://plumvillage.org/letter-from-dr-martin-luther-king-jr-nominating-thich-nhat-hanh-for-the-nobel-peace-prize-in-1967.

[93] Marc Andrus, *Brothers in the Beloved Community: The Friendship of Thich Nhat Hanh and Martin Luther King Jr.* (Berkeley: Parallax Press, 2021).

[94] Sulak Sivaraksa, *Seeds of Peace: A Buddhist Vision for Renewing Society* (Berkeley: Parallax Press, 1992), 1–15.

[95] Sulak Sivaraksa, *Conflict, Culture, Change: Engaged Buddhism in a Globalizing World* (Boston: Wisdom Publications, 2005), 67.

B. R. Ambedkar (1891–1956) represents a distinct stream of Engaged Buddhism arising from India's Dalit liberation movement. Ambedkar, an Indian jurist, economist, social reformer, and the principal architect of the Indian Constitution, converted to Buddhism in 1956, along with hundreds of thousands of his followers, rejecting caste hierarchy and adopting Buddhism as a foundation for social equality.[96] For Ambedkarite Buddhists, the Dharma is primarily a force of liberation for oppressed communities. They focus on the Buddha's teachings about human dignity and social hierarchy. This tradition has inspired continuing social justice movements and continues to shape Buddhist chaplaincy, especially in settings that serve marginalized populations.[97]

Contemporary Engaged Buddhist networks have expanded to include topics as diverse as environmental protection, gender justice, and peacebuilding. Groups such as the Zen Peacemakers, founded by Bernie Glassman (1939–2018), apply Buddhist principles to working with homeless people, resolving conflicts, and remembering the Holocaust.[98] Sōka Gakkai International, a lay Buddhist movement that originated in Japan, has a long history of advocacy for nuclear disarmament, sustainable development, and human rights education, which they present as expressions of Buddhist compassion in action.[99]

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[96] B. R. Ambedkar, *The Buddha and His Dhamma* (Bombay: Siddharth College Publication, 1957).

[97] On Ambedkarite Buddhism and contemporary social justice, see Eleanor Zelliot, *Ambedkar's World: The Making of Babasaheb and the Dalit Movement* (New Delhi: Navayana, 2013).

[98] Bernie Glassman, *Bearing Witness: A Zen Master's Lessons in Making Peace* (New York: Bell Tower, 1998).

[99] Andrew Gebert, "Sōka Gakkai," in *Oxford Research Encyclopedia of Religion*, ed. John Barton (New York: Oxford University Press, 2024), https://doi.org/10.1093/acrefore/9780199340378.013.196.

Core Principles

Scholars characterize Engaged Buddhist practice as being defined by several interrelated principles. Interdependence (*paṭiccasamuppāda* in Pāli; *pratītyasamutpāda* in Sanskrit) provides the foundational philosophical framework. If all phenomena arise in dependence on causes and conditions, then individual suffering cannot be separated from social conditions; conversely, transforming social conditions becomes a legitimate domain of Buddhist practice. As Thich Nhat Hanh expresses it through his concept of "interbeing," "We are here to awaken from the illusion of our separateness."[100]

Compassion (*karuṇā*) functions not merely as an internal feeling but as an impetus to action. The bodhisattva ideal central to Mahāyāna Buddhism—the vow to attain enlightenment for the sake of all beings—provides a model of compassionate engagement that refuses any ultimate distinction between personal liberation and collective well-being.[101] For Engaged Buddhists, compassion necessarily expresses itself in efforts to alleviate the systemic causes of suffering, not merely its individual manifestations.

Nonviolence (*ahiṃsā*) constitutes both ethical commitment and strategic principle. Inspired by the first Buddhist precept (refraining from taking life), Engaged Buddhists have participated in nonviolent resistance movements in Asia and the West. This commitment to nonviolence is not limited to physical harm but includes structural

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[100] Nhat Hanh, *Peace Is Every Step: The Path of Mindfulness in Everyday Life* (Berkeley: Parallax Press, 1991), 106.

[101] On the bodhisattva ideal, see the classic treatment by Har Dayal, *The Bodhisattva Doctrine in Buddhist Sanskrit Literature* (London: Kegan Paul, Trench, Trubner & Co., 1932).

violence; for committed Buddhists, violence is perpetuated not only by physical attack but also by economic systems, racial hierarchies, and environmental destruction.[102]

Traditional mindfulness practice has been aimed at individual liberation, but it also extends to collective awareness of social conditions. Engaged Buddhists cultivate an awareness of patterns of consumption, political participation, and relationships to institutions, recognizing that these are the domains that create the context within which suffering can flourish or recede.[103]

Relationship to Buddhist Chaplaincy

The interconnections of Engaged Buddhism, Humanistic Buddhism, and Buddhist chaplaincy deserve scrutiny. All three movements share historical roots and overlapping concerns: they all apply Buddhist teachings to suffering in contemporary contexts, emphasize compassionate action, and emerged mainly in the late twentieth and early twenty-first centuries. But they differ greatly in focus and methodology.

Humanistic Buddhism emerged in early twentieth-century China and was further developed in Taiwan. It calls for integrating Buddhist practice into everyday life and social affairs, rather than restricting it to monastic or ritual contexts. This kind of integration typically happens at both the institutional level (e.g., schools, hospitals, and charities) and the community level.

Engaged Buddhism, often associated with Thich Nhat Hanh and others, that emphasizes timely social and political action in response to war, injustice, and environmental crises. Buddhist Chaplaincy is influenced by both Humanistic and

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[102] David Loy, *The Great Awakening: A Buddhist Social Theory* (Boston: Wisdom Publications, 2003), 145–78.

[103] Nhat Hanh, *Peace Is Every Step*, 115–22.

Engaged Buddhism. It is most often found in clinical, educational, and military contexts, where it provides pastoral and spiritual care rather than pursuing more radical structural change. In this sense, Humanistic Buddhism provides a general philosophical basis for Buddhist engagement with the world, Engaged Buddhism gives this engagement a more explicit activist orientation, and Buddhist Chaplaincy brings these concerns into concrete caregiving practice.

However, a growing number of Buddhist chaplains are turning to Engaged Buddhist frameworks to make sense of their work. This awareness—that individual suffering cannot be separated from broader social conditions—shapes how they respond to patients facing racism, economic insecurity, and institutional violence.[104] The bodhisattva ideal offers a model of compassionate presence that remains steady in the face of suffering. Likewise, the emphasis on mindfulness as a way of meeting difficulty directly strengthens chaplains' ability to remain present with those in distress.

Recent initiatives explicitly connect Engaged Buddhism and chaplaincy. The International Young Bodhisattva Program (IYBP), sponsored by INEB, brings together emerging Buddhist leaders for training that integrates contemplative practice with social engagement; its curriculum includes attention to spiritual care as a dimension of engaged practice. As one IYBP facilitator noted, "The collective is a modern version of sangha wherein each person shares equal responsibility for mutual healing."[105] This framing

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[104] Ann Gleig, "Engaged Buddhism," in *Oxford Research Encyclopedia of Religion*, ed. John Barton (New York: Oxford University Press, 2021), https://doi.org/10.1093/acrefore/9780199340378.013.755.

[105] Ajayan Idukki, "Young Bodhisattvas Pave the Way for Socially Engaged Buddhism," Buddhistdoor Global, published November 14, 2025, https://www.buddhistdoor.net/features/young-bodhisattvas-pave-the-way-for-socially-engaged-buddhism/.

positions chaplaincy not as a separate profession but as one expression of Buddhism's fundamental commitment to responding to suffering.

The relationship between Engaged Buddhism and the present study is implicitly conveyed in the title itself, specifically in the phrase "engaged in" CPE. In Engaged Buddhist terms, to be engaged in a practice means to bring the Dharma directly into sites of suffering—hospitals, prisons, hospices—rather than retreating into purely meditative or monastic seclusion. This is precisely what the Zen Peacemakers' Three Tenets cultivate: Not-Knowing, Bearing Witness, and Taking Action.[106] Buddhist chaplains adopt the Three Tenets as a framework for their pastoral practice: not-knowing as a suspension of clinical certainty, bearing witness as embodied presence to another's suffering, and taking action as the compassionate response that arises from the first two. For monastics, CPE has served as a laboratory for socially engaged Buddhist practice, a space where the bodhisattva vow meets the raw, lived realities of emergency rooms and deathbeds. This study, therefore, takes Engaged Buddhism not as an abstract doctrine but as a phenomenological structure through which Buddhist monastics make sense of their clinical training, a structure that transforms the hospital into a field of engaged spiritual practice.

Professional Identity, Role, and Boundaries in Chaplaincy

The literature on professional identity formation offers an important theoretical resource for understanding how Buddhist monastics negotiate CPE. This section reviews

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[106] "The Three Tenets," Zen Peacemakers, accessed April 23, 2026, https://zenpeacemakers.org/three-tenets/. See also Bernie Glassman, *Instructions to the Cook: A Zen Master's Lessons in Living a Life That Matters* (New York: Bell Tower, 1996), 89–92, for the classic articulation of the Tenets as a framework for engaged action.

literature on professional identity in religious occupations, explores theoretical frameworks to understand identity work in boundary-spanning roles, and considers the particular challenges of maintaining a religious identity while adapting to professional contexts shaped by different assumptions.

Theoretical Perspectives of Professional Identity

Professional identity is defined as "the relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role."[107] This formulation, taken from the psychology of work, stresses the integration of personal and professional dimensions: professional identity is not just a role played but part of one's self-understanding.

Sociological approaches to professional identity emphasize that it is socially constructed and continuously negotiated. As Tony Watson argues, identity work involves "the mutually constitutive processes whereby people strive to shape a relatively coherent and distinctive notion of personal self-identity and struggle to come to terms with and, within limits, to influence the various social identities that pertain to them in the various milieux in which they live their lives."[108] This perspective recognizes that the formation of professional identity occurs in institutional contexts that both provide and constrain opportunities for self-understanding.

For religious professionals specifically, identity formation involves distinctive complexities. Religious leadership draws on holistic qualities of personhood, character,

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[107] Herminia Ibarra, "Provisional Selves: Experimenting with Image and Identity in Professional Adaptation," *Administrative Science Quarterly* 44, no. 4 (December 1999): 764, https://doi.org/10.2307/2666995.

[108] Tony J. Watson, "Managing Identity: Identity Work, Personal Predicaments and Structural Circumstances," *Organization* 15, no. 1 (January 2008): 121, https://doi.org/10.1177/1350508407084488.

and spiritual formation, rather than on specialized knowledge or technical skills as the primary basis for identity, as is the case in many other professions. Carrie Doehring's work on pastoral identity indicates the integration of "theological commitments, spiritual practices, and personal history" as resources for pastoral functioning.[109] In secular or multifaith professional contexts, such integration may require a renegotiation of how religious commitments inform practice.

Boundary Theory and Role Hybridity

Boundary theory provides useful conceptual tools for analyzing how professionals navigate multiple domains. As Akkerman and Bakker define them, boundaries are "sociocultural differences leading to discontinuity in action or interaction."[110] Boundaries are not inherently problematic; they can be sites of learning and creativity. But when individuals must cross boundaries between different professional worlds, they face the challenges of translation, negotiation, and potential identity conflict.

Recent chaplaincy research has applied boundary theory to understand interfaith collaboration. A Dutch participatory action research study examining a multifaith chaplaincy team found that "the diverse worldviews and the contradictory visions of their role in the chaplaincy's professional identity led to misunderstandings and conflict."[111] However, researchers also found that "engaging in dialogue about worldviews and

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[109] Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach*, rev. ed. (Louisville: Westminster John Knox Press, 2015), 23.

[110] Sanne F. Akkerman and Arthur Bakker, "Boundary Crossing and Boundary Objects," *Review of Educational Research* 81, no. 2 (2011): 152, https://doi.org/10.3102/0034654311404435.

[111] Iris R. Wierstra et al., "Interfaith Collaboration: Boundary Crossing in a Participatory Action Research Project with Health Care Chaplains in The Netherlands," *Journal of Religion and Health* 64, no. 2 (2025): 1068–86, https://doi.org/10.1007/s10943-024-02185-3.

seeking connections across differences is the basis for a shared professional identity."[112] This finding suggests that boundaries, while potentially divisive, can also become sites of productive engagement when approached with appropriate practices.

The concept of a hybrid professional identity illuminates situations where individuals are required to integrate seemingly contradictory roles. Research on Swedish military chaplains, for example, points to the need for "continuous identity work to maintain clerical integrity while adapting to military culture." These chaplains serve as ordained Lutheran priests, but they also carry weapons for self-defense.[113] As a result, they occupy "a liminal position, fully belonging neither to the military community nor to the ecclesiastical sphere," and must engage in "ongoing negotiation of professional boundaries and personal values."[114] Although Buddhist monastics in CPE confront a different set of challenges, their experience of navigating between institutional worlds with competing demands may share important structural similarities.

Role Negotiation in the Clinical Environment

Specific role expectations permeate the clinical environment, potentially misaligning with the self-understandings of religious professionals. Healthcare institutions expect chaplains to function as members of interdisciplinary teams, document their work in medical records, respect patient autonomy, and coordinate care with other providers. These expectations, developed largely in contexts shaped by Western medicine

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[112] Wierstra et al., "Interfaith Collaboration," 1068.

[113] Jan Grimell, "'Am I a Priest in the Armed Forces, or a Soldier Who Is a Priest?' Identity Work among Military Chaplains in the Swedish Armed Forces," *Frontiers in Sociology* 10 (October 2025), https://doi.org/10.3389/fsoc.2025.1645776.

[114] Grimell, "'Am I a Priest.'"

and its assumptions, may not, naturally, make room for Buddhist monastic understandings of spiritual care.[115]

Wendy Cadge's ethnography of American hospital chaplains illustrates the ways in which religious professionals negotiate their roles in secular settings. She points to chaplains developing "professional projects" that allow them to articulate their distinctive contributions and work within institutional constraints.[116] Cadge suggests that adaptation is not wholesale accommodation or rigid resistance but creative translation: figuring out how to express core religious commitments in ways that make sense in the clinical setting without compromising one's integrity to one's tradition.

Role negotiation, especially for Buddhist monastics, can involve questions of proper forms of presence, speech, and action. The monastic codes (Vinaya) regulate behavior in ways that may not fit easily with clinical expectations. For example, rules concerning physical contact with the opposite sex, appropriate forms of address, or the performance of rituals may require careful interpretation when applied in clinical settings. How monastics navigate these questions while maintaining both monastic integrity and clinical effectiveness remains underexplored in the existing literature.

Power, Authority, and Religious Difference

Critical perspectives on professional identity in chaplaincy also raise questions of power and authority in interreligious encounters. Chaplaincy training, including CPE, was developed within Christian frameworks and continues to reflect Christian assumptions, even when adapted for multi-religious participation. As Sanford and

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[115] Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012), 145–72.

[116] Cadge, *Paging God*, 168.

Michon note, "many of the educational, training, and professional standards for certification or licensing are still normed against Christian expectations and legacy organizational structures."[117] This reality creates potential for implicit pressure on non-Christian trainees to conform to Christian-normative models of pastoral identity.

Questions of authority also emerge in the clinical encounters. Religious professionals from traditions with strong hierarchical structures may approach patients differently than those from traditions emphasizing egalitarian relationships. Monastics, who in many Buddhist cultures occupy positions of veneration and authority, may need to adjust when functioning as chaplains in settings where patients hold ultimate authority over their own care. Such adjustments need to be empirically investigated to understand how they affect monastic identity and self-understanding.

Cross-Cultural and Interfaith Encounters in Healthcare

As healthcare settings become increasingly more diverse in terms of patients and staff, the complex dynamics of cross-cultural and interfaith encounters have become more prominent. This section provides a review of literature on religious diversity in health care, considers research on interfaith collaboration among providers, and then discusses the unique challenges and opportunities Buddhist engagement in predominantly Christian chaplaincy contexts presents.

Religious Diversity and Patient Care

Healthcare systems in pluralistic societies must be ready to serve patients from diverse religious backgrounds, as their beliefs and practices may impact medical

[117] Sanford and Michon, "Buddhist Chaplaincy."

decision-making, responses to illness, and preferences for end-of-life care.[118] A recent German survey on religious considerations in medical practice uncovered significant gaps among healthcare professionals in their knowledge of minority traditions such as Islam and Buddhism. The researchers concluded that "the complexity and diversity of interpretations within each faith, depending on personal and cultural preferences, have to be considered in personalized medicine."[119]

Healthcare providers' religious literacy significantly impacts patient outcomes. When religious needs go unrecognized or unfulfilled, individuals may experience spiritual distress, diminished trust in their providers, and lower adherence to treatment.[120] Chaplains can be important in meeting these needs, but they also need to know about religious and cultural traditions other than their own. For example, in multifaith settings, Buddhist chaplains need to be aware of the differences in perspectives on suffering, healing, and death within and across traditions.

Research into cross-cultural spiritual care has identified several core competencies essential to effective practice, such as awareness of one's own cultural assumptions, knowledge of the beliefs and practices of diverse traditions, skills in assessing spiritual needs across cultural boundaries, and the ability to adapt interventions accordingly.[121] For Buddhist chaplains, developing these competencies may require engaging with traditions very different from their own—especially those with theistic

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[118] Tim Ford, "Interacting with Patients of a Different Faith: The Personal Reflection of a Buddhist Chaplain," *Southern Medical Journal* 99, no. 6 (2006): 658–60.

[119] Tekbaş et al., "Intersection of Religious Beliefs."

[120] Christina Puchalski et al., "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference," *Journal of Palliative Medicine* 12, no. 10 (2009): 885–904.

[121] Lartey, *In Living Color*, 78–95.

worldviews, different understandings of death and the afterlife, and distinct ritual practices.[122]

Interfaith Collaboration Among Providers

Religious diversity in healthcare chaplaincy teams is both a challenge and an opportunity. Research on multifaith teams has shown that differences in world view can lead to misunderstanding and conflict, particularly where team members have different views on the role of religion in professional identity. The previously cited Dutch study found that "in secular contexts, worldview remains significant in chaplaincy" and that it is essential to engage differences constructively to develop a shared professional identity.[123]

Successful interfaith collaboration requires what some scholars term "boundary crossing competence"—the ability to navigate differences without erasing them. Strategies to facilitate crossing boundaries include making space to talk explicitly about differences in worldview, developing shared language for common purposes while honoring differences, and building relationships that allow for trust across differences.[124] Such strategies are particularly relevant to Buddhist monastics in CPE who are called to work with supervisors and peers from other traditions while remaining faithful to their own practice commitments.

Interfaith collaboration must be sensitive to power. Members of minority traditions may feel pressure to conform, or their voice may be silenced where the

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[122] Raweewan Pilaikiat et al., "Development of a Buddhist Spiritual Care Model for People at the End of Life," *Journal of Hospice & Palliative Nursing* 18, no. 4 (2016): 324–31.

[123] Wierstra et al., "Interfaith Collaboration."

[124] Akkerman and Bakker, "Boundary Crossing," 132–69.

dominant tradition is dominant in numbers or institutional power. Such dynamics may be observed among Buddhist participants in predominantly Christian CPE settings, especially when core concepts—prayer, God, and salvation—are embedded in training materials and discussions in ways that assume Christian frameworks.[125]

Translation and Adaptation of Concepts

Cross-cultural encounters in chaplaincy involve ongoing processes of translation and adaptation. Buddhist monastics in CPE must translate their tradition's concepts into terms intelligible within clinical settings; conversely, they must translate clinical concepts and CPE frameworks into Buddhist terms. This dual translation work is both demanding and potentially generative.

The translation of the term "chaplain" provides a prime example. Bhante Kusala's reflections on the search for appropriate Pāli terms illustrate the process of finding functional, rather than strictly literal, equivalents in a faithful translation.[126] The terms he and Charles Hallisey proposed, *paradukkha seviya* (one who searches for others who suffer) and *ajjhattika sahāyaka* (spiritual supporter), capture aspects of chaplaincy while grounding them in Buddhist understandings of suffering and support.

Other key concepts are treated to similar translation. The imagery of pastoral care in Jewish and Christian traditions, with its shepherd-flock connotations, needs reinterpretation in Buddhist contexts. In particular, the term "supervision," with its hierarchical overtones, may need to be adapted to settings where monastic relationships

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[125] For discussion of Christian dominance in chaplaincy training, see Mosher, "Toward a Pedagogy," 118

[126] Kusala, "Can a Buddhist Monk."

involve different dynamics of authority. “Verbatim” may need to be supplemented by attention to non-verbal presence and silence, as it assumes verbal exchange as central.

These translation difficulties are linguistic but also conceptual and pragmatic. They raise profound questions about the nature of suffering, the purpose of care, and the role of the caregiver. However, existing literature on CPE and Buddhism has paid little attention to how Buddhist monastics address these questions, what sorts of translations they develop, and what adaptations and resistances they maintain.

Summary and Gaps in the Literature

This review has surveyed literature across multiple domains relevant to understanding Buddhist monastics’ experiences in CPE. Several significant gaps emerge from this survey that the proposed study aims to address.

Limited Empirical Research on Buddhist CPE Participants

Despite the growth of Buddhist participation in CPE and the emergence of Buddhist chaplaincy as a recognized profession, empirical research on Buddhist trainees’ experiences remains extremely limited. Sanford and Michon note that “as an emerging field, there is little literature on Buddhist chaplaincy, so it is currently somewhat difficult to say what theories and practices will come to dominate the profession.”[127] This gap is particularly acute regarding CPE experiences: while numerous studies examine Christian trainees’ experiences and a smaller body of literature addresses Jewish and Muslim trainees, Buddhist participants have received minimal attention.

[127] Sanford and Michon, “Buddhist Chaplaincy.”

The existing literature includes reflective accounts by Buddhist practitioners (such as Bhante Kusala's Harvard Divinity Bulletin essay) and program descriptions from Buddhist chaplaincy training institutions.[128] What is lacking is systematic qualitative research examining how Buddhist monastics actually experience CPE—what challenges they encounter, what resources they draw upon, and how their understanding of both Buddhism and chaplaincy develops through the training process.

Tensions Between Monastic Formation and CPE Methodology

A second gap concerns the specific situation of Buddhist monastics as distinct from lay Buddhist practitioners. Monastics undergo distinctive formation processes, observe distinctive precepts, and occupy distinctive social locations. These features may create particular tensions when monastics enter CPE—tensions not necessarily shared by lay Buddhists or by monastics from other traditions.

An underexplored question is how Buddhist chaplaincy differs from monastic roles across various Buddhist traditions, as well as from chaplaincy as taught in CPE programs developed within Christian contexts. For example, the focus of Humanistic Buddhism on the everyday as spiritual practice, the denial of escapism from the material world, the dedication to institutional engagement, and the recognition of lay participation in spiritual life all have the potential to influence how monastics trained in this tradition approach the work of spiritual care. This study aims to contribute to an empirical examination of the interaction between these distinctive orientations and the methodologies and assumptions of CPE.

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[128] See, for example, the program descriptions at "MDiv in Buddhist Chaplaincy," Institute of Buddhist Studies, accessed January 15, 2026, https://www.shin-ibs.edu/academics/mdiv/.

The literature on professional identity formation in chaplaincy has not systematically addressed how prior religious formation (including monastic formation) interacts with CPE's developmental goals. While research on military chaplains illuminates some dynamics of navigating between institutional worlds, the specific features of Buddhist monastic formation—including its emphasis on renunciation, its training in specific meditation practices, and its relationship to lay communities—remain unexplored in relation to CPE.

Need for Phenomenological Approaches

The methodological orientation of existing chaplaincy research, while valuable, has tended toward either quantitative outcome studies or qualitative research focused on program evaluation and professional development. Phenomenological approaches—which focus on participants' lived experiences and how they make sense of their situations—remain underrepresented.

IPA offers particular promise for this domain. IPA's commitment to understanding how individuals make sense of significant life experiences, its attention to both shared themes and individual particularity, and its recognition of the researcher's interpretive role align well with the questions this study pursues.[129] No published research to date has applied IPA to Buddhist monastics' CPE experiences.

Cross-Cultural Adaptation of CPE

Finally, the literature exhibits little sustained attention to the need to adapt CPE methodology for participants from non-Western, non-Christian backgrounds. While CPE has grown internationally and has served a variety of religiously diverse participants, the

[129] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 3.

fundamental assumptions of the model—its emphasis on verbal articulation of feeling states, its expectation of intensive self-disclosure, and its particular understanding of "pastoral identity"—may reflect culturally specific values that need to be critically examined.

Questions about the cultural appropriateness of CPE are especially important for Buddhist monastics, whose traditions may emphasize different modes of learning, different teacher/student relationships, and different understandings of self and its expression. Unexplored is how monastics navigate these potential tensions and how CPE programs might adapt to better serve Buddhist participants.

The proposed study fills these gaps by presenting the first systematic phenomenological investigation of Buddhist monastics' lived experience in CPE. This study seeks to add to the academic literature on Buddhist chaplaincy and the practical work of CPE educators who seek to serve diverse student populations by paying attention to how participants make meaning of this experience, the challenges they face, and the resources they utilize.

Chapter Three:

Methodology

Philosophical and Theoretical Foundations

This study employs Interpretive Phenomenological Analysis (IPA) as its methodological framework. IPA is a qualitative research approach that focuses on the systematic exploration of personal experiences and examines how individuals make sense of their personal and social worlds.[130] This methodology is particularly well suited to research that aims to understand how participants perceive and make sense of significant life experiences, making it an appropriate choice for exploring the lived experiences of Buddhist monastics undergoing CPE.

IPA is grounded in three foundational philosophical pillars: phenomenology, hermeneutics, and idiography. Together, these interconnected traditions provide both a theoretical foundation and an analytic sensibility that guide this research.

Phenomenology

Phenomenology, as the study of human experience and the way in which things appear to consciousness, forms the first pillar of IPA. It draws on the work of philosophers such as Edmund Husserl, Martin Heidegger, and Maurice Merleau-Ponty and directs attention to the lifeworld: the world as it is lived and immediately experienced rather than as it is conceptualized or categorized.[131] IPA's phenomenological commitment therefore requires researchers to attend to how a phenomenon is experienced

[130] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 1.
[131] Smith, Flowers, and Larkin, 11–21.

by the individual, giving priority to participants' subjective perspectives over objective or external accounts.

In this study, the phenomenon under investigation is Buddhist monastics' experiences of participating in CPE, a clinical training program originally developed in Christian pastoral settings. A phenomenological approach enables us to access the "stream of consciousness" of participants—their thoughts, feelings, and memories—as they engage in this distinctive form of clinical education. Importantly, IPA makes an "explicit commitment to person-in-environment," recognizing that experience is always context-dependent and shaped by social, historical, and cultural factors.[132] Accordingly, Buddhist monastics' experiences of CPE are mediated by their religious formation, cultural background, and the institutional contexts of both their monastic communities and the healthcare settings in which they practice.

Hermeneutics

The second philosophical foundation of IPA is hermeneutics, the theory and practice of interpretation. IPA recognizes that understanding of another's lived experience is never direct or unmediated, but rather emerges through an interpretive process. This hermeneutic dimension is closely related to Heidegger's concept of *Dasein*, which emphasizes that human existence is always situated and interpretive.[133]

Central to IPA's hermeneutic orientation is the concept of the *double hermeneutic*. As Smith and Osborn put it, "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their

[132] Linda Y. K. Lee et al., "Navigating Challenges in Using Interpretative Phenomenological Approach with Photovoice: A Systematic Review," *International Journal of Qualitative Methods* 24 (2025): 3.

[133] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 16.

world."[134] This dual-layer interpretation recognizes that meaning-making unfolds on two levels: first, through the participant's own reflective engagement with their experiences, and second, through the researcher's analytical engagement with the participant's account. The double hermeneutic thus points to a dynamic, iterative process in which the researcher seeks to take an "insider" perspective while acknowledging that full access to another person's experience is ultimately unattainable.[135]

The hermeneutic tradition also introduces the concept of the *hermeneutic circle*, the idea that understanding a text as a whole requires attention to its parts, and understanding its individual parts requires attention to the whole. This circular movement between part and whole, and between the participant's account and the researcher's interpretation, characterizes the analytical process in IPA.[136]

The double hermeneutic is of particular importance for this study. As a researcher studying Buddhist monastics, I enter with an interpretive lens shaped by my doctoral training in Buddhist ministry and my knowledge of both Buddhist traditions and clinical chaplaincy contexts. This fore-structure of understanding, in Heidegger's terms, is not an obstacle to be overcome, but rather a necessary condition for interpretation.[137] Through reflexive engagement with my own presuppositions, I can use them productively to make sense of how participants make sense of their own experiences.

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[134] Jonathan A. Smith and Mike Osborn, "Interpretative Phenomenological Analysis," in *Qualitative Psychology: A Practical Guide to Research Methods*, ed. Jonathan A. Smith (London: SAGE Publications, 2008), 53.

[135] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 36.

[136] Smith, Flowers, and Larkin, 27.

[137] See Martin Heidegger, *Being and Time*, trans. John Macquarrie and Edward Robinson (New York: Harper & Row, 1962), 191–95: "Interpretation is grounded in something we have in advance—a fore-having; something we see in advance—a fore-sight; and something we grasp in advance—a fore-conception; all interpretation, moreover, operates in the fore-structure, which we have already characterized."

Idiography

The third philosophical commitment of IPA is idiography, a concern with the particular and the specific.[138] Idiographic inquiry entails the in-depth examination of individual cases, in contrast to nomothetic approaches, which seek to establish general laws that apply across populations. IPA seeks to understand how particular individuals, in their unique contexts, make sense of a given phenomenon.

This idiographic commitment is methodologically manifested in two ways. First, IPA tends to employ small samples that are purposively selected to allow for detailed analysis of each case before moving to cross-case comparisons. Second, the analysis is attentively aware of the particularities of each participant's account, so that individual voices do not get lost in generalized themes. As Noon notes, "Each individual case is central to IPA research; the investigator seeks to understand as much as possible about each respective case before progressing to the next."[139]

The idiographic orientation is important in this study because Buddhist monastics are not a monolithic group. They represent the full range of Buddhist traditions (Theravāda, Mahāyāna, Vajrayāna), cultural backgrounds, and monastic lineages. These particularities influence how they experience CPE. Idiographic analysis permits these diverse voices to emerge and also assists in identifying patterns that shed light on shared dimensions of their experience.

Epistemological Position

IPA adopts an epistemological stance that recognizes the situated and interpretive character of knowledge. It doesn't claim to produce objective facts about an external

[138] Smith, Flowers, and Larkin, 29.
[139] Noon, "Interpretive Phenomenological Analysis," 77.

reality but, rather, offers a set of interpretations of how individuals make meaning of their experiences.[140] This position is consistent with a critical realist ontology, the view that while a real world exists, our access to it is always mediated by human interpretation and meaning-making.[141]

In this research, the epistemological aim is not to determine whether Buddhist monastics "correctly" understand CPE or to evaluate their clinical performance against external standards. Rather, it is to understand how they experience and make meaning of their participation in CPE, how they negotiate their dual identities as monastics and clinical caregivers, and how they draw upon Buddhist teachings in clinical encounters. These objectives are congruent with the three research questions that underpin this study, as discussed in Chapter 1.

Research Design and Participant Recruitment

Research Design Overview

This study employs a qualitative research design guided by IPA methodology. The design is structured to generate rich, detailed, first-person accounts of Buddhist monastics' experiences in CPE programs across the United States. Consistent with IPA's idiographic commitment, the design prioritizes depth over breadth, seeking to understand each participant's unique lifeworld while also identifying patterns of meaning across cases.[142]

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[140] Smith and Osborn, "Interpretative Phenomenological Analysis," 51.
[141] Lee et al., "Navigating Challenges," 4.
[142] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 38.

The research design is organized around three research questions as specified in Chapter 1: the central question asks how Buddhist monastics experience and make meaning of their participation in CPE; the first sub-question explores how they negotiate their dual roles as Buddhist renunciates and clinical spiritual caregivers within healthcare institutional contexts; and the second sub-question examines how they draw on Buddhist teachings and practices in clinical encounters and reflective learning within CPE.

These questions reflect IPA's concern with both experience (phenomenology) and meaning-making (hermeneutics), while the focus on a specific population (Buddhist monastics) honors the idiographic commitment to understanding a particular group sharing a common phenomenon.

Sampling Strategy

IPA requires a purposively selected, fairly homogeneous sample. The logic of purposive sampling in IPA is not to achieve representativeness or generalizability but to ensure that the research question holds personal significance for participants and that they can provide rich, detailed accounts of the phenomenon under investigation.[143]

For this study, the inclusion criteria are as follows:

- Current or former Buddhist monastic (*bhikkhu*, *bhikkhunī*, or other renunciate status) who has taken vows within a recognized Buddhist tradition
- Completion of at least one unit of CPE in an accredited program within the United States
- Willingness to complete a preliminary questionnaire and participate in an in-depth interview

[143] Smith, Flowers, and Larkin, 46.

- Ability to communicate effectively in English (the language in which interviews will be conducted)

The sample is homogeneous in that all participants share the experience of being Buddhist monastics who have undergone CPE. However, within this homogeneity, diversity is anticipated across Buddhist traditions (Theravāda, Mahāyāna, Vajrayāna), demographic characteristics, and CPE status (from one unit to chaplain residency). This combination of shared experience and individual difference is typical of IPA sampling.[144]

Smith, Flowers, and Larkin suggest a sample size of between 4 and 10 participants for professional doctorates.[145] This spectrum seeks to reconcile the idiographic commitment to detailed case analysis with the pragmatic concerns of generating sufficient data to develop meaningful cross-case patterns. Using this guidance, the present study aims to recruit 6 to 8 participants. This sample size allows for a detailed examination of each individual transcript as well as the identification of themes that illuminate the common dimensions of participants' experiences.

Recruitment Procedures

Participants were recruited through multiple channels to ensure access to the target population. Recruitment strategies included:

1. Recruitment through referrals from faculty, alumni, and current students at the University of the West, leveraging their networks to identify eligible Buddhist monastics
2. Utilizing snowball sampling, wherein initial participants could refer other eligible monastics

[144] Noon, "Interpretive Phenomenological Analysis," 76.
[145] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 51.

3. Disseminating recruitment information through professional listservs and academic networks related to Buddhist ministry and chaplaincy

The study was conducted in two sequential phases. In Phase 1, potential participants were recruited to fill out an anonymous online questionnaire distributed via Google Forms. A total of twelve participants completed the survey. No personally identifying information was collected, and all responses were recorded anonymously. An information statement and consent details were provided on the first page of the survey, and consent was indicated by proceeding to the questionnaire. The questionnaire is provided in Appendix H.

In Phase 2, participants who wished to take part in follow-up interviews contacted the researcher separately (i.e., outside the anonymous survey) to express their interest. Seven participants took part in the interview phase. Before interviews were scheduled and conducted, eligible participants received an information sheet outlining the study's purpose, procedures, and ethical safeguards, and they were asked to provide informed consent. The information sheet and consent form are included in Appendix F.

Questionnaire Administration

Before the interview, participants completed a brief questionnaire (see Appendix H). The questionnaire was designed to (a) collect demographic and background information, (b) document participants' CPE status and prior experience, and (c) elicit initial reflections on their perceptions of the CPE experience.

The questionnaire included items on age, gender, ethnicity, Buddhist tradition, and CPE status, along with fifteen Likert-scale questions addressing multiple dimensions of the CPE experience (e.g., perceived learning outcomes, supervisory relationship,

integration of Buddhist identity, and challenges encountered). These Likert-scale items were not intended for hypothesis testing or inferential statistical analysis; rather, they served as an orienting tool to highlight salient themes and to help both the participant and the researcher identify areas that might be explored in greater depth during the interview.

In addition to the structured items, the questionnaire ended with an open-ended question asking participants to describe an important experience from their CPE process. This aspect of narrative gave contextual richness and often proved an effective entry point for interview discussion so that participants could ground subsequent reflections in concrete events and meanings.

In addition to its role as a data-gathering device, the questionnaire had a practical preparatory function. It introduced the core themes of the study in advance; it helped participants to recall relevant episodes, to clarify key terms, and to do some initial self-reflection before the interview.[146] This kind of pre-interview sensitization is common practice in qualitative research and can enhance the depth, specificity, and coherence of participants' interview accounts.

The questionnaire collected demographic information, responses to fifteen Likert-scale items, and two open-ended questions inviting narrative accounts of significant learning experiences and additional feedback. A total of 12 participants completed the questionnaire. As reported in Appendix B (Statistical Summary of Questionnaire Data), respondents were predominantly Asian (91.7%) and female (66.7%), with ages ranging from 36 to over 50. Participants represented a range of Buddhist traditions: Participants represented three broad Buddhist traditions: East Asian Mahāyāna (75%), i.e., Chinese

[146] Patrick Schmidt, "From Doxastic to Epistemic: A Typology and Critique of Qualitative Interview Styles," *Qualitative Inquiry* 25, no. 10 (2019): 1012–13.

(41.7%), Korean (16.7%), Japanese (8.3%), and Vietnamese (8.3%); Thai Theravāda (16.7%); and Tibetan Vajrayāna (8.3%). Their CPE status ranged from current trainees to board-certified chaplains, offering perspectives across multiple stages of professional formation.

Responses to the Likert-scale items indicate that 91.7% of respondents found experiential learning beneficial, and 84.6% reported that CPE challenged their self-image as monastics. One participant summarized this transformative impact succinctly: "The CPE program helped me learn about myself, self-compassion, self-care, and others."[147] While 91.7% valued working with people from diverse religious backgrounds, 58.3% reported difficulty fitting into the CPE environment. Another respondent explained that CPE helped them maintain their own firm foundation while revealing the essence of Buddhism in a way that non-Buddhists could appreciate and enjoy the fruitful results of their teachings.[148]

Specifically, 91.7% of respondents reported applying Buddhist approaches during patient visits, and 91.7% indicated that CPE helped them think critically about Buddhist spiritual care. One respondent's extended reflection on palliative care work further illustrates this integration:

> I have learned that my ability to show up for suffering can help a patient be present. It is also important to let go of hopes and expectations for a particular outcome. And, even more, I have learned that my attachment to a so-called good outcome can actually cause more suffering. When I visit with patients who are dying, I want to do whatever I can to relieve their pain and suffering… I need to respect the truth of this experience, accept it, be penetrated by it, be present to my own responses, and then remember that suffering and pain are transitory.[149]

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[147] Questionnaire Response 01, July 22, 2020.
[148] Questionnaire Response 05, July 24, 2020.
[149] Questionnaire Response 12, December 09, 2020.

The questionnaire data provide additional quantitative support for the key themes that emerged from the interviews and validate that the experiences of the individual participants are representative of broader patterns in the general population. Qualitative information from questions with open answers is also used to enrich the interview results and is often able to capture complex experiences in a few powerful words.

Data Collection: Semi-Structured Interviews

Rationale for Semi-Structured Interviews

IPA is best suited to data collection approaches that "invite participants to offer a rich, detailed, first-person account of their experiences."[150] Although IPA can draw on various data sources—including diaries and focus groups—semi-structured interviews remain the most commonly used method, as they are particularly well-suited to the phenomenological and hermeneutic commitments of the approach.

Semi-structured interviews offer several advantages for this study. They first allow participants to tell their own stories in their own words, which promotes freedom of expression and immersion in the interview process. Second, the flexible structure allows the researcher to follow unanticipated directions of inquiry that may arise during the conversation, bringing out features of experience that pre-set questions may not reveal. Third, the interview is interactive, and the rapport and trust that can be developed are important (to generate the kind of intimate, detailed accounts that IPA requires).[151]

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[150] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 56.
[151] Smith, Flowers, and Larkin, 59–62.

Design of Interview Schedule

A semi-structured interview schedule has been developed to guide the interviews (see Appendix I: Interview Questions). The schedule employs a funneling technique, starting with broad, open-ended questions and then moving to more specific probes. The method is designed to enhance memory recall and to allow participants to develop their own narrative frame before focusing on specific topics of interest.

The interview schedule consists of two major parts. The Background section poses questions about the participants' monastic background and their reasons for choosing CPE. These initial questions are intended to gather contextual information and to help the interview process by encouraging the participants to discuss aspects of their lives that are familiar to them.

The Direct Questions section contains ten main questions. Each question addresses one aspect of the research questions. These questions examined participants' experience of the CPE program, their evaluation of their own performance, their comfort with clinical visits, the advantages and disadvantages they experienced as Buddhist monastics, their understanding of their role, their use of Buddhist concepts, and their opinions of the value of CPE for Buddhist monastics. The questions were open-ended and non-directive, allowing participants to elaborate on their experiences in the way they felt appropriate and not be constrained by presuppositions of the researcher.

The schedule also contains possible prompts and probes to be used to elicit elaboration or clarification in addition to the main questions. For example, if a participant refers to a challenging clinical encounter, the interviewer may ask, "Can you tell me more

about what that was like for you?" or "How did you make sense of that experience?"[152] These probes are not pre-written but are a reflection of the interviewer's active engagement with the account of the participant.

Interview Procedures

Interviews were conducted online via a secure video conferencing platform (Zoom Communications, Inc.). The Zoom platform was also used to create initial audio recordings of each session. This modality offered several advantages: it enabled participation from monastics located across the United States, accommodated participants' schedules and geographic constraints, and provided a setting in which participants could feel at ease in their own environment. Consistent with IPA guidelines, interviews were expected to last approximately 60 to 90 minutes.[153] However, the actual duration ranged from 40 to 120 minutes (see Table 1).

Before each interview, I reviewed the consent form with the participant, addressed any questions, and confirmed the participant's willingness to proceed. Participants were reminded that they could decline to answer any question and were free to withdraw from the study at any time. The interviews were recorded using the recording function of Zoom, with the permission of the participants, to ensure an accurate transcription. Seven in-depth interviews were conducted for this study. Most of the interviews, specifically five, were conducted in August 2020. One interview was conducted at the beginning of September, and another one was rescheduled to January 2021 because of scheduling problems.

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[152] Smith, Flowers, and Larkin, 76.
[153] Smith, Flowers, and Larkin, 60.

In the interviews, I used active listening skills, demonstrated empathy, and paid close attention to rapport-building, techniques important in eliciting rich data in IPA research.[154] The interview schedule was not a rigid protocol but a flexible guide; I listened carefully to the stories of participants and followed up on emerging lines of inquiry as appropriate. This responsiveness is indicative of IPA's interest in making sense of the participant's lifeworld from their perspective.

Post-Interview Procedures

I prepared a verbatim transcript after each interview. To facilitate this process, I initially processed the audio recordings using automated transcription software (Otter.ai, Inc.). I then listened repeatedly to the original recordings and carefully checked and corrected the machine-generated transcripts, comparing the wording with the audio. This manual verification process allowed us to confirm that the final transcripts were a true and accurate reflection of each interview. In addition to the spoken words, the transcripts also include my notations of meaningful pauses, emotional expressions, and other paralinguistic features that I observed and that might inform subsequent interpretation.

Because six of the seven participants were non-native English speakers, some had difficulty expressing themselves fluently in spoken English. Proofreading the interview transcripts was therefore quite challenging: I often had to listen to the recordings repeatedly to confirm exactly which words were said. In addition, there were many hesitations, repetitions, and uncertain phrasing. In editing the transcripts, I have tried to keep the original wording as much as possible and have only made major grammatical changes when they served to make the meaning more explicit. Consequently, some direct

[154] Smith, Flowers, and Larkin, 64–67.

quotations may have small grammatical issues. However, the intended meaning should still be clear, and the quotations should better reflect the participants' tone and state at the time of the interview. Over-editing to "perfect" their speech could reduce readers' ability to pick up on these important nuances.

Each participant was assigned a pseudonym, and all identifying information was removed or anonymized during this transcription phase, unless explicit consent was obtained from the participant to retain specific details. The table below provides an overview of the interviews conducted and the associated transcripts:

Table 1: Overview of Interview Data and Documentation

Pseudonym	**Interview Date**	**Recording Duration**	**Transcript**
John	August 07, 2020	00:40:26	Interview 01
Dora	August 13, 2020	01:01:01	Interview 02
Hope	August 14, 2020	00:43:36	Interview 03
Faye	August 30, 2020	01:05:45	Interview 04
Lynn	August 30, 2020	02:02:12	Interview 05
Wynn	September 4, 2020	00:42:20	Interview 06
Mona	January 12, 2021	00:38:16	Interview 07

In the course of the data collection and preliminary analysis, I kept a reflexive journal in which I noted immediate impressions after each interview, personal reactions, methodological choices, and related analytical ideas. I also wrote down contextual details and reflections on how my positionality and assumptions might be influencing what I noticed and how I interpreted participants' accounts. This journal supported the hermeneutic process by creating an audit trail of evolving understandings so that my interpretive engagement with the data was transparent and ongoing reflexivity was possible as themes and interpretations evolved.

Data Analysis: The IPA Analytic Process

The interview data were analyzed for this study in accordance with the IPA approach as defined by Smith, Flowers, and Larkin.[155] IPA is committed to understanding how individuals make sense of their lived experience, and it involves a detailed, systematic examination of each participant's account before moving to cross-case analysis. The analytic process was iterative, cyclical, and characterized by a constant movement between part and whole—between the individual transcript and the emerging themes, between one participant's account and others, and between the data and interpretative insights.

This section provides a detailed account of the analytic process employed, including the six steps adapted from Smith, Flowers, and Larkin: (1) reading and re-reading; (2) initial noting; (3) developing emergent themes; (4) searching for connections across emergent themes; (5) moving to the next case; and (6) looking for patterns across cases.[156] This section also addresses issues of quality and validity in IPA research, including the researcher's reflexive engagement with the data.

The Six-Step Analytic Process

Step 1: Reading and Re-reading

The analysis began with a deep reading of each transcript. Following the advice of Smith, Flowers, and Larkin, I read each transcript multiple times in order to become intimately familiar with the participant's account. I started by listening to the audio recordings of the interviews, and this enabled me to attend to the tone, pacing, pauses,

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[155] Smith, Flowers, and Larkin, 79.
[156] Smith, Flowers, and Larkin, 82–101.

and emotional inflections that may not be entirely captured in the written text alone. This auditory engagement allowed me to be more fully immersed in the participant's lifeworld, attending not just to the content of their speech, but also to how it was delivered.

For the transcription, I did several iterative readings and listened back to the recordings to verify their accuracy. Once each transcript was complete, I read it again on its own. Before beginning formal notation/coding, I read each transcript at least three times. During these readings, I kept a reflexive journal to record initial impressions, emotional reactions, and early analytic notes. For example, I noted my surprise at how strongly I reacted and that I seemed to notice similar dynamics in other participants after reading Dora's account of discovering her emotional "wall." These reflexive notes became an important data source for clarifying my interpretive stance and identifying potential biases.

The reading and re-reading phase also involved paying attention to the overall structure and narrative flow of each interview. I noted where participants introduced key themes, returned to particular topics, and struggled or hesitated. These notes helped inform the next stage of analysis and to identify areas of particular importance or emotional intensity.

Step 2: Initial Noting

The second step was detailed, line-by-line, notes on each transcript. In line with Smith, Flowers, and Larkin's guidance, I employed a three-part approach to initial noting: descriptive comments, referring to content; linguistic comments, referring to language use; and conceptual comments, referring to interpretive engagement.[157]

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[157] Smith, Flowers, and Larkin, 84.

Descriptive comments captured what participants explicitly said: the events, experiences, and meanings they described. For example, when John described how his teachers endorsed his work as a chaplain as "living the Dharma," I paid attention to the descriptive fact of this affirmation and its place in his story. When Faye talked about standing helpless in front of a patient in pain, I noted the chain of events and her emotional reaction.

Linguistic comments attended to how participants used language, including specific words, metaphors, pacing, repetition, and pauses. For example, Dora's description of her robe as "my skin" was noted as a powerful linguistic formulation revealing the depth of her attachment. Lynn's repeated use of the words "struggle" and "balance" throughout her interview was identified as a core linguistic pattern. Hope's distinction between the terms "interfaith" and "multifaith" was noted as a precise linguistic choice that carries significant meaning. Wynn's metaphor of Buddhism as a "gem" that patients lack the energy to receive was identified as a key linguistic construction.

Conceptual comments involved more interpretative engagement, asking what the participant's words might mean and what broader significance they might carry. These comments were tentative and open-ended, framed as questions rather than assertions. For example, in response to Faye's account of her Phantom City revelation, I asked, "Is she finding a way to understand her role that honors both Buddhist teachings and clinical practice?" "Does this represent a hermeneutic breakthrough?" In response to Mona's description of Korean Christian bias, I asked: "How does this additional burden shape her experience of CPE?" "What does it mean to be a chaplain from a minority tradition?"

Step 3: Developing Emergent Themes

The third step was to develop the first notes into emergent themes. This was a move from working with the transcript and notes to working with increasingly abstract formulations that captured the essence of what was important in each section. Smith, Flowers, and Larkin describe this process as a shift from the participant's own words to the researcher's interpretative phrasing—a collaborative product of the participant and the analyst.[158]

Emergent themes were developed by reviewing initial notes and condensing them into concise phrases that captured the psychological essence of each passage. The phrases were intended to be specific enough to be rooted in the text, but abstract enough to permit linking across the transcript. For example, the emergent theme "Discovering the Wall" encompassed not only Dora's literal description of her emotional wall but also its psychological significance from her perspective. In Lynn's ongoing negotiation between identities, the emergent theme "The Fundamental Puzzle" drew on her words while pointing to broader significance.

The emergent themes were noted in the right margin of the transcript, along with the relevant text and initial notes. Themes were numbered sequentially and linked to specific line numbers to anchor them in the data. John's interview revealed emerging themes of "Living the Dharma" (his teachers' affirmation), "Interconnectedness" (his foundational principle), and "Karma's Clinical Limitations" (his reflection on not using karma with grieving families).

This phase demanded careful attention to preserving the participant's voice while moving toward interpretative formulation. I repeatedly checked back to the original

[158] Smith, Flowers, and Larkin, 92.

transcript to ensure that themes were based in what the participant actually said and not simply speculation.

Step 4: Searching for Connections Across Emergent Themes

The fourth step was to cluster emergent themes into higher-order groupings reflecting higher-order patterns within a participant's account. In this step, experiential statements were cut and grouped by abstraction, subsumption, polarization, contextualization, and numeration.[159] It was an active, creative process of looking for connections, contrasts, and relationships between themes. I employed several strategies, as directed by Smith, Flowers, and Larkin:

The abstraction was to group similar themes under a superordinate theme. For example, Faye's analysis abstracted the themes "Feeling Like an Outsider," "Theological Otherness," and "Multiple Dimensions of Otherness" into the superordinate theme "The Experience of Being an Outsider."

Then there was subsumption, when one theme was important enough to subsume others. Lynn's analysis of "The Fundamental Puzzle" contained several related themes about identity negotiation, boundary struggles, and role confusion.

Polarization was about looking at opposite relationships between themes. For Dora, the contrast between "The Wall" (emotional protection) and "Emotional Awakening" (discovering feelings) was a polar pair that organized her narrative.

Contextualization was about considering themes in relation to their narrative context, what preceded and followed them, and how they were introduced and developed in the interview. Her initial instrumental motivation ("to improve my English"), as

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[159] Smith, Flowers, and Larkin, 97.

Mona's analysis shows, was constructed by her later awareness of authentic value, thus creating a narrative arc from disinterest to valuation.

Numeration was directed by how often themes emerged. It was not a quantitative measure but an indicator of salience. "Struggle" and "balance" were repeated throughout the interview, suggesting how central they were to Lynn's experience.

Using these strategies, I developed a table of superordinate themes and constituent themes for each participant. The tables were used to develop the idiographic case narratives in Chapter 4. For example, John's superordinate themes were "The Integration of Monastic Identity and Chaplaincy Practice," "The Intersection of Buddhist Teachings and Clinical Realities," "The CPE Experience as Buddhist Practice and Professional Formation," and "The Distinctive Contributions of Buddhist Chaplaincy," with several subordinate themes for each (see Table 3).

Step 5: Moving to the Next Case

The fifth step was to bracket the insights from one case and proceed to the next with fresh attention. Smith, Flowers, and Larkin advocate for the significance of evaluating each case independently, allowing new themes to emerge naturally without imposing a connection to prior cases.[160] This was both an analytic discipline and a reflexive practice.

For bracketing, I maintained a reflective journal, writing down my evolving understanding of each case before proceeding to the next. After I finished analyzing John's interview, I wrote a summary of key themes and noted my emotional and

[160] Smith, Flowers, and Larkin, 100.

intellectual responses. And then I deliberately pushed the summary to one side and began to work on the transcript of Dora. This was the experience of every participant.

The aim of this step was not to achieve full neutrality (an impossible and perhaps undesirable goal in interpretative research) but to ensure that the voice of each participant was heard clearly. The idiographic commitment of IPA also means that each case must be understood on its own terms before we search for patterns across cases.[161]

Step 6: Looking for Patterns Across Cases

The sixth and final step was to go from an idiographic analysis to a cross-case synthesis. This was a creative and interpretative process of pattern recognition, of convergence and divergence across accounts of participants. I approached this step with several questions in mind: What themes cut across multiple participants? What themes are unique to certain individuals? How do participants from different backgrounds (e.g., different Buddhist traditions, different CPE settings) experience similar phenomena in different ways?

I created a master table of superordinate themes for all seven participants, organized to reveal patterns. For example, the theme "Negotiating Visible Monastic Identity" appeared in all seven accounts, though with different emphases: Dora's "robe as skin," Hope's experience of wearing full robes at Cedars-Sinai, Wynn's compromise with Japanese robes, and Mona's encounter with Korean Christian bias. The cross-case analysis revealed both commonality (all participants experienced their visible identity as significant) and variation (the specific challenges and meanings differed).

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[161] Smith, Flowers, and Larkin, 32.

Other patterns emerged through this comparative process. The theme "Emotional Awakening" was prominent in Dora's and Lynn's accounts but less so in others—perhaps reflecting their particular trajectories and perhaps suggesting individual differences in monastic formation. The theme "Questioning Effectiveness" was distinctive to Wynn, raising questions about whether her setting (children's hospital) or her personal orientation contributed to this concern.

The cross-case analysis also revealed what Smith, Flowers, and Larkin call "convergence and divergence"—patterns where participants shared common experiences but with unique inflections.[162] All participants struggled with the relationship between their monastic identity and their emerging chaplain identity; however, they conceptualized this relationship in various ways: as "living the Dharma" (John), as "the fundamental puzzle" requiring balance (Lynn), as clear role differentiation (Mona), as selective identity expression (Faye), as discovering previously hidden aspects of self (Dora), as enjoying institutional support (Hope), and as questioning overall effectiveness (Wynn).

The analytic procedure resulted in a set of superordinate and associated subordinate themes that captured both common patterns and individual variations across the seven participants. These themes formed the structural frame for the idiographic case narratives and cross-case analysis in Chapter 4.

The Role of In Vivo and Thematic Codes in Analysis

Throughout the analytic process, I maintained systematic documentation of codes at multiple levels of abstraction. Following the guidance of Saldaña, I distinguished

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[162] Smith, Flowers, and Larkin, 166.

between in vivo codes (using participants' own words) and thematic codes (researcher-generated phrases capturing patterns).[163] These codes served as intermediate analytic products that facilitated movement from raw data to interpretative themes.

In vivo codes were identified during initial noting and recorded as exact phrases from participants. Examples included "a bodhisattva experience" (Faye), "my skin" (Dora referring to her robe), "the fundamental puzzle" (Lynn), "a wall" (Dora), "living the Dharma" (John), and "gem" and "stone" (Wynn). These codes preserved participants' own formulations and served as touchstones for subsequent interpretation.

Thematic codes were developed during emergent theme analysis and represented my interpretative condensation of patterns. Examples included "Negotiating Visible Monastic Identity," "The Emotional Awakening of Protected Selves," "Distinguishing Monastic and Chaplain Roles," and "The Challenge of Buddhist Language in Clinical Context." These codes facilitated cross-case comparison and the development of superordinate themes.

Code groups were formed by clustering related thematic codes into higher-order conceptual categories. For example, the code group "The Fundamental Puzzle of Balance" included thematic codes such as "Boundary Struggles," "Identity Confusion Risk," "Flexibility in Identity," and "Professional Boundaries." These code groups corresponded roughly to the superordinate themes that structure the case narratives.

Appendix C provides a complete list of in vivo codes with participant attribution and context. Appendix D lists thematic codes organized in alphabetical order with descriptions. Appendix E presents code groups with summaries of each group's

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[163] Johnny Saldaña, *The Coding Manual for Qualitative Researchers*, 4th ed. (London: SAGE Publications, 2021).

significance. These appendices follow the analytic trail from raw data to interpretative findings and thus serve to support the transparency and trustworthiness of the analysis.

Quality and Validity in IPA Analysis

Quality in IPA is assessed in a different way than quantitative or positivist research. Rather than applying criteria such as validity, reliability, and generalizability, IPA researchers look at the coherence, transparency, and persuasiveness of the interpretative account.[164] The issue of quality and validity in IPA needs to take into account several criteria. To ensure methodological rigor, the study applied a variety of methods drawing on quality frameworks relevant to qualitative research and IPA. Yardley proposes four principles for evaluating qualitative research: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance.[165] These principles guided my analytical practice throughout the research process.

Sensitivity to context was demonstrated through careful attention to the existing literature on Buddhist chaplaincy and CPE; through the idiographic commitment to understanding each participant's unique context, the specific circumstances of each participant—their Buddhist tradition, cultural background, CPE setting, and personal history—and through the use of verbatim excerpts that ground interpretations in participants' own words.[166] The idiographic commitment of IPA requires understanding each participant's account in its full context before seeking patterns. This was achieved through detailed initial noting and the maintenance of contextual information throughout analysis.

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[164] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 182.

[165] Lucy Yardley, "Dilemmas in Qualitative Health Research," *Psychology & Health* 15, no. 2 (2000): 215–28, https://doi.org/10.1080/08870440008400302.

[166] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 180.

Commitment and rigor were evidenced by the careful selection of a purposive homogeneous sample, the quality of the interview interactions, and the thoroughness of the analytical process following the established six-step procedure.[167] Such methodological integrity was further demonstrated through thorough engagement with each transcript (multiple readings, line-by-line notation, systematic theme development) and through attention to both convergent and divergent patterns. Rigor required not only finding themes that fit multiple participants but also attending to disconfirming evidence and individual variations.

Transparency and coherence were achieved through detailed documentation of all methodological decisions and the analytic process, including the creation of audit trails linking raw data to emergent themes to final interpretations, clear articulation of the research process, and reflexive engagement with the researcher's own position and presuppositions. The appendices documenting codes and code groups serve this transparency function. Coherence was pursued through the careful organization of themes into meaningful structures that told a coherent story about each participant's experience. The inclusion of the interview schedule and questionnaire in the appendices contributes to this transparency.

Impact and importance were addressed by ensuring that the research addresses questions of genuine significance to Buddhist communities, chaplaincy educators, and healthcare institutions seeking to support diverse spiritual care providers. It will further be assessed by readers and by the study's contribution to understanding Buddhist monastics' engagement with CPE, as the study aims to provide insights that may inform

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[167] Smith, Flowers, and Larkin, 82–101.

training programs, support Buddhist chaplains, and contribute to the broader literature on interfaith spiritual care.

In addition to Yardley's principles, I also followed Smith, Flowers, and Larkin's guidance on quality in IPA specifically.[168] This included ensuring that interpretations were grounded in participants' accounts (rather than imposed from outside), that sufficient verbatim evidence was provided to support claims, that both convergence and divergence were attended to, and that the interpretative element of analysis was explicit rather than disguised as mere description.

Reflexivity and the Double Hermeneutic

IPA recognizes that the researcher's interpretations are situated and partial; this means that the analysis involves a "double hermeneutic," where the researcher interprets the participant's understanding of their own experience.[169] This recognition requires ongoing reflexive attention to the researcher's own position, assumptions, and responses.

As a Buddhist monastic myself, having similar training and struggling with similar questions of identity and practice, I had insider knowledge and personal stakes in this research. There were benefits to being an insider: a knowledge of Buddhist ideas and practices, an awareness of monastic formation, and a shared language with the participants. There were also risks: over-identification, assumptions of shared meaning, and the difficulty of maintaining critical distance.

I handled these risks by means of a series of reflexive practices. First, throughout the research process, I maintained a reflexive journal in which I documented my emotional responses, assumptions, and developing interpretations. After each interview, I

[168] Smith, Flowers, and Larkin, 179.
[169] Smith, Flowers, and Larkin, 187.

wrote down my reactions and questions. During analysis, I tracked moments when my own experience seemed to align with or diverge from participants' accounts. Second, I paid close attention to instances when participants' experiences diverged from mine or from patterns I expected to discover. For example, Wynn's questioning of the effectiveness of CPE challenged my own largely positive view of chaplaincy training and required me to take her perspective seriously, rather than dismiss it as anomalous. Third, I maintained proximity to the data throughout the writing process by frequently returning to the transcripts to compare my interpretations with participants' actual words. This technique kept my interpretations rooted even as they moved into the abstract.

The double hermeneutic in IPA is not a problem to be solved but a condition to be acknowledged and worked with. My training as a Buddhist monastic researcher working with Buddhist monastic participants presented both opportunities and challenges—opportunities for insight and the challenges of maintaining a critical perspective. The reflexive practices described above enabled me to navigate this terrain while honoring both the participants' voices and my own interpretive role. The following section will elaborate on a more comprehensive exploration of researcher positionality and reflexivity as a methodological practice.

Summary

Data analysis in this study was consistent with the systematic, idiographic approach of IPA. Using the six analytic steps of IPA (reading and re-reading, initial noting, developing emergent themes, searching for connections, moving to the next case, and looking for patterns across cases), I worked from raw interview transcripts toward an interpretative understanding of the lived experiences of seven Buddhist monastics of CPE.

The analysis was supported by multi-level, systematic coding (in vivo codes, thematic codes, and code groups) and guided by widely used criteria for quality in qualitative research: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance.[170] I used ATLAS.ti, a qualitative data analysis software, to manage the volume of data and to maintain clear links among data excerpts, exploratory notes, and thematic codes.[171] Throughout the process, I remained attentive to the double hermeneutics central to the IPA and practiced ongoing reflexivity regarding my position as a Buddhist monastic researcher.

In Chapter 4: Findings, I present the results of this analytical process, including idiographic case narratives and cross-case analysis. In this chapter, I bring together participants' voices and my interpretive reflections to illuminate experiences of Buddhist monastics engaging in CPE in the United States.

Researcher Positionality and Reflexivity

IPA recognizes the researcher as central to the interpretative process. The researcher engages in ongoing reflexivity, examining how their own fore-structures, experiences, and presuppositions shape interpretation, instead of trying to remove their influence (which is impossible given the hermeneutic nature of the approach).[172] Recent scholarship has emphasized that appropriate use of reflexivity in IPA studies enables

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[170] Yardley, "Dilemmas in Qualitative."

[171] Steven Wright, "Interpretative Phenomenological Analysis: Completing and Enhancing the Process with ATLAS.ti," in *SAGE Research Methods Datasets* (London: SAGE Publications, 2024).

[172] Linda Finlay, "A Dance Between the Reduction and Reflexivity: Explicating the 'Phenomenological Psychological Attitude,'" *Journal of Phenomenological Psychology* 39 (June 2008): 1–32, https://doi.org/10.1163/156916208X311601.

researchers to recognize the personal and professional influences on the research process.[173]

In conducting this study, as a researcher, I need to be explicit about my positionality. I am a doctoral student in Buddhist ministry with academic training in Buddhist studies and qualitative research methods. I'm a Buddhist monastic myself, and I'm also familiar with CPE programs and clinical chaplaincy settings. There are strengths and challenges to this positionality. My knowledge of Buddhist traditions and chaplaincy helped me to understand the language and context of the participants, which may have allowed for a more meaningful interpretive engagement. However, my insider status relative to monastic experience also required me to remain attentive to assumptions I might impose and to privilege participants' own meaning-making.

A distinctive feature of my research process is its temporal structure: Before participating in CPE, I had already determined my research objectives, methods, and questions. During my CPE process, I developed the research proposal, questionnaire, and interview schedule. After completing one unit of CPE, I carried out participant recruitment, distributed the questionnaire, and conducted interviews. Data analysis and dissertation writing were then conducted following that CPE unit.

This sequence has important reflexive implications. It means that, during research design, I had no first-hand experience of CPE's routines, evaluation culture, or supervisory process; later, during data collection and analysis, I brought an embodied understanding of CPE that could enrich interpretation but also introduce new assumptions.

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[173] Iyore M. Ugiagbe et al., "Thinking Theoretically in Nursing Research-Positionality and Reflexivity in an Interpretative Phenomenological Analysis (IPA) Study," *Nursing Inquiry* 32, no. 1 (2025): e12684, https://doi.org/10.1111/nin.12684.

Throughout the project, I therefore treated reflexivity as an ongoing practice across phases of the study rather than a single statement of positionality.

Insider–Outsider Dynamics

My position in relation to the participant group is best described as both insider and outsider in different ways and at different stages of the research.

As a Buddhist monastic myself, I occupied an insider position; meanwhile, I remained a partial outsider given that the interviewees came from diverse Buddhist traditions and regional cultural backgrounds. I share with participants a renunciant identity and many aspects of monastic habitus: the centrality of precepts/vows, lineage accountability, daily practice commitments, and a vocational orientation toward alleviating suffering. This insider location shapes the interview relationship. It may have supported rapport and trust, and it may have allowed participants to speak more directly about monastic concerns (e.g., discipline, community expectations, forms of authority, or the moral texture of caregiving) without extensive explanation. It also gave me sensitivity to how Buddhist categories—such as suffering, impermanence, compassion, and non-harming—are not merely concepts but lived frameworks that inform attention, intention, and conduct.

As someone who is only partially familiar with monastic practices in Buddhist traditions different from my own, I need to remain mindful of my positionality. That is, I want to avoid projecting my assumptions or biases, and I want to avoid influencing how participants express their views. During the data analysis stage, I need to be particularly alert to meanings, practices, or terms that are unfamiliar to me so that I can approach

them with care and reflexivity instead of filling interpretive gaps with my own assumptions.

When I began designing this study and formulating the research questions, I had not yet participated in CPE. At that stage, I was an outsider to the embodied and institutional realities of CPE, including the rhythm of clinical work, the pressure of evaluation, the interpersonal intensity of process groups, and the specific modes of learning (e.g., verbatims, supervisory critique). This outsider position brought strengths as well as limitations. One strength was that I could approach the study with fresh curiosity and pose research questions without assuming a common CPE experience. It also meant that I was probably not fully prepared for the emotional and organizational weight that participants gave to certain aspects of the training or the tacit norms embedded in CPE discourse.

My positionality shifted after the completion of the research proposal, when I undertook one unit of CPE at MedStar Georgetown University Hospital before conducting the formal questionnaire survey and interviews. This experience moved me, at least in part, from outsider to insider. Participating in CPE gave me a more grounded understanding of the reflective learning practices, institutional language, and emotional labor involved in clinical presence. It also broadened my awareness of what is required to conduct interviews sensitively and to interpret participants' accounts with greater contextual understanding. This insider perspective strengthened the analysis by enabling me to recognize more subtle dimensions of participants' narratives (e.g., how supervision impacts self-understanding, how peer feedback functions as formation, or how institutional expectations are negotiated).

At the same time, this shift in position introduced new methodological risks. In particular, there was a possibility of treating my own CPE experience as typical or normative and interpreting participants' accounts through that lens. Such a tendency would be especially problematic when participants were formed in settings that differed significantly from mine in terms of institutional context, supervisory style, or cohort dynamics. For this reason, my insider experience required ongoing reflexive attention. Rather than assuming equivalence between my experience and that of participants, I sought to treat my CPE unit as one situated experience among many and to remain attentive to difference, variation, and dissonance in the data.

To address this, I treated my CPE experience as contextual knowledge rather than as interpretive authority. In my analytical memos, I recorded instances where my own CPE experience affected my interpretations and inquired, "Is this assertion based on the participant's meaning-making, or am I projecting my own narrative?" This reflexive practice was consistent with IPA's commitment to remaining closely engaged with participants' accounts while recognizing the researcher's active role in the interpretive process.

In summary, my positioning is not a fixed insider/outsider status but a layered, time-sensitive relationship to the phenomenon: an insider to monastic life throughout, yet a partial outsider to unfamiliar monastic traditions; an outsider to CPE during the research design phase and a partial insider to CPE during data collection and analysis (since the CPE program I completed differed from those of the interviewees). Making this movement explicit is essential for transparency and for evaluating the interpretive claims advanced in later chapters.

Positioning and Reflexive Practices

Researchers using IPA must remain reflexive, sensitive to context, and intentional in engaging participants as co-constructors of meaning in phenomenological inquiry.[174] Throughout the research process, I maintained a reflexive journal, in which I recorded my reactions to interviews, my developing interpretations, and my awareness of how my position may have influenced the research. This journal supported the hermeneutic process and contributed to the transparency of the final account. This sort of reflexive practice is crucial to guaranteeing what some scholars call "cross-cultural validity and reliability" in IPA research.[175]

As an international student in the United States, I also inhabit a cross-cultural position within U.S. higher education and American healthcare chaplaincy. This location sensitizes me to cultural assumptions embedded in "professionalism," institutional communication styles, and expectations around self-disclosure and feedback—features that often surface in CPE culture. It also shapes how I hear participants' accounts of belonging, marginality, or misunderstanding within training and clinical contexts.

Language is also part of my positionality. Participants may draw on Buddhist vocabularies from Pāli, Sanskrit, Tibetan, Chinese, Japanese, or vernacular discourse. While I am familiar with many Buddhist terms, I do not assume shared meanings across traditions. My own linguistic background inevitably shapes what words I pick out and how I initially understand them. To counter this, I consciously set aside my preconceptions and remain open to participant-generated meanings. In this study, I treat

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[174] Tiani Wepener, "Interpreting Adolescent Experience: Methodological Lessons from IPA in Geography Education Research," *The Professional Geographer* 77, no. 5 (2025): 557–68, https://doi.org/10.1080/00330124.2025.2539213.

[175] Ugiagbe et al., "Thinking Theoretically."

Buddhist language as emic and contextual. I am interested in how participants use terms in particular clinical or formative moments and what those terms are doing within their narratives.

During interviews, I aimed to cultivate a stance consistent with qualitative ethics and monastic practice: attentive listening, non-judgment, and respect for boundaries. Because participants were discussing training and institutions marked by evaluation and power (e.g., supervisors, professional standards, institutional policies), I emphasized confidentiality and voluntary participation, and I avoided questions that could be perceived as evaluative or as requests to judge particular supervisors or programs.

Given my prior CPE experience in conducting interviews, I intentionally used descriptive prompts, inviting participants to walk me through concrete episodes ("What happened?" "How did you respond?" "What was it like for you?") and meaning prompts ("What did that mean to you as a monastic?"). This approach helped ensure that the accounts were grounded in lived experience rather than general opinion, and it reduced the likelihood of imposing a preconceived CPE framework onto participants' narratives. The approach helped ensure that accounts were grounded in lived experience rather than general opinion and reduced the likelihood that I would impose a preconceived CPE framework onto participants' narratives.

Reflexivity became especially important during analysis and writing. I engaged in iterative transcript reading, analytic memo-writing, and theme development consistent with IPA's idiographic commitment. I also explicitly monitored moments when my own CPE experience was activated—particularly when I felt strong resonance ("I know exactly what they mean") or strong disagreement ("That's not how CPE works"). In such

moments, I returned to the participant's account and asked what meaning they were making in their context and what interpretive claim I could responsibly support with evidence.

In presenting my findings, I also tried to avoid treating participants as representatives of "Buddhism" or of "monasticism" as a unified category. Buddhist monastic life is diverse across traditions, cultures, and institutional settings, much like CPE programs are. The analytic goal of IPA is to achieve depth and nuance rather than broad generalization. I intend to lay out some interpretive themes based on certain cases that could be advantageous in comparable clinical training contexts.

Another important dimension to the study of monastics in clinical training is vulnerability. Participants may describe experiences of conflict, marginalization, or spiritual struggle. They may describe a patient and family in crisis. It is my responsibility to maintain confidentiality and to represent participants with care and integrity. Given that this dissertation is likely to be read by CPE educators, healthcare chaplaincy leaders, and Buddhist communities, I want to write honestly and constructively, pointing to complexities without sensationalizing difficulty or idealizing either CPE or monastic life.

In conclusion, my position as a Buddhist monastic and international doctoral student shapes this project at every stage. My positionality encompasses a deep insider relationship to monastic life, while my relationship to CPE shifts from being an outsider during the research design phase to a partial insider during data collection and analysis after completing one unit of CPE. In my reflexive practice across design, interviewing, analysis, and writing, I aim to interpret participants' narratives with transparency,

humility, and rigor, in line with IPA's interpretive commitments and the ethical responsibilities of research in clinical and religious contexts.

Gender and Ethnicity

The researcher's gender and ethnicity shaped this study from its earliest stages, beginning with participant recruitment, and continued to influence rapport, interpretive sensibilities, and the reflexive work required throughout analysis. As a female Chinese Buddhist monastic researcher, I found that this positionality carried both relational openings and constraints within U.S. Buddhist communities, particularly given the cultural and gendered dynamics that often structure monastic interaction, authority, and comfort with self-disclosure.

My identity likely affected who felt inclined to respond to my invitation and who did not. From the outset, Buddhist nuns appeared more receptive to participating, while monks seemed less willing to engage—though this phenomenon can also be partially attributed to limitations in my sampling method. This pattern is consistent with my experiential understanding of how gendered boundaries and norms of propriety may shape a monastic's willingness to discuss emotionally intimate or institutionally sensitive topics such as CPE, identity negotiation in healthcare settings, and experiences of vulnerability in formation.

This tendency was noticed in the study's recruitment process. Among the twelve respondents who completed the questionnaire, four were men, and eight were women. In terms of race/ethnicity, eleven participants identified as Asian and one as White. In terms of Buddhist traditions, nine participants identified with East Asian Mahāyāna Buddhism: five with Chinese traditions, two with Korean, one with Japanese, and one with

Vietnamese. Two participants identified with Thai Theravāda Buddhism, and one identified with Tibetan Vajrayāna Buddhism.

The sample was narrowed to seven participants who ultimately took part in the in-depth interviews: one White man who identified with Tibetan Buddhism and six Asian women who identified with Chinese (four), Korean (one), and Vietnamese (one) Buddhist traditions. Table 2 below presents the demographic characteristics of the questionnaire sample and the interview subsample.

Table 2: Participant Composition (Questionnaire vs. Interview)

	Buddhist Tradition		Male	Female	Ethnicity
Questionnaire	Mahāyāna	Chinese		5	Asian
		Korean		2	Asian
		Japanese	1		Asian
		Vietnamese		1	Asian
	Theravāda	Thai	2		Asian
	Vajrayāna	Tibetan	1		White
Interview	Mahāyāna	Chinese		4	Asian
		Korean		1	Asian
		Vietnamese		1	Asian
	Vajrayāna	Tibetan	1		White

Although the study was not designed to be statistically representative, the recruitment results indicate that my positionality may have affected both access and willingness to participate, thereby influencing whose lived experiences are highlighted in the interpretive dataset.

My positionality also influenced the relational dynamics during interviews. I found it easier to connect emotionally and empathetically with my fellow female monastics, especially those from China. Shared cultural assumptions and religious understanding, and familiarity with linguistic and nonverbal cues, probably lowered

barriers to trust and permitted richer narrative accounts. At the same time, this "insider proximity" also generated reflexive concerns: the same common ground that facilitates depth can also foster over-identification, unspoken assumptions, or premature closure in interpretation.

This tension was particularly evident in the themes that emerged around robes and emotion. As a monastic, I have lived CPE firsthand and have experienced the embodied visibility of robes in clinical settings, and so I was immediately able to recognize the stakes of these accounts—how clothing operates not only as clothing but also as a symbolic boundary, a public signifier of religious identity, and a site where vulnerability, expectation, and self-regulation can intensify. My own lived familiarity might have helped me listen more attentively, but it also risked shaping what I first noticed, what I silently agreed with, what I might have thought I "already knew." To achieve this, I engaged in intentional bracketing-as-reflexivity[176] (rather than claiming total neutrality), asking myself repeatedly: What is the participant saying that differs from my own experience? What am I assuming because it is culturally familiar? What might I be missing because it is culturally unfamiliar?

A further reflexive layer concerns the social positioning of Asian women in religious leadership and in professional contexts such as pastoral care and healthcare chaplaincy in the United States. Asian female monastics may encounter specific forms of misunderstanding, marginalization, or misrecognition shaped by intersecting dynamics of race, gender, accent, religious minority status, and assumptions about authority. Although these structural issues form part of the wider context in which CPE takes place, this

[176] Viktor Dörfler and Marc Stierand, "Bracketing: A Phenomenological Theory Applied through Transpersonal Reflexivity," *Journal of Organizational Change Management* 34, no. 4 (2021): 778–93, https://doi.org/10.1108/JOCM-12-2019-0393.

dissertation does not attempt an extended sociological analysis of systemic inequity. Instead, I note this context as a reflexive reminder: participant narratives may carry meanings formed under conditions that are not fully visible within individual stories alone. Naming this possibility helped me remain cautious about overly individualized interpretations while still staying faithful to what participants explicitly disclosed.

Because of my own background, I made sure to analyze the data in a way that fairly represents what the interviewees said, without judging their views or using the results to decide what is "right" or "wrong" about monastic practices, CPE models, or cultural norms. This dissertation grounds its findings in the interview data from the seven participants who completed interviews. Accordingly, this study does not claim to represent all Buddhist monastics engaged in CPE in the United States, nor does it generalize across traditions, lineages, genders, or ethnic communities. Instead, it offers an interpretative phenomenological analysis of the lived experiences of these seven participants, while openly acknowledging that my gendered and ethnic identity shaped access, resonance, and interpretation and therefore required continuous reflexive attention from recruitment through writing.

Ethical Considerations

This study involved human participants; therefore, all ethical considerations were addressed in accordance with relevant ethical principles and institutional requirements. Ethical practice in qualitative research requires "democratic, reflexive, and responsive

processes in all phases of research,"[177] necessitating attention to both procedural ethics (institutional approval) and ethics in practice (ongoing ethical decision-making throughout the research process).[178]

Written informed consent (see Appendix F) was obtained from all interviewees before the interviews/data collection. The consent form clearly explained the study's purpose, procedures, potential risks and benefits, and participants' rights, including the right to withdraw at any time without consequence. Participants were able to ask questions before agreeing. The process of obtaining informed consent was developed following the established principles of qualitative research that regard the giving of consent as an ongoing act of relational practice rather than a one-off event.[179] This approach is built on trust, attentiveness to context, and ongoing dialogue between the researcher and participants. Throughout the process, participants were regularly reminded of their rights and the study's purpose.

To protect participants' confidentiality, data were pseudonymized, identifying information was removed from transcripts, and all data were stored securely. Participants were also informed that although every effort was made to ensure confidentiality, such assurances could not be guaranteed given the depth and detail of qualitative accounts.

Protection from harm also included consideration of potential emotional and psychological effects of participation. The interview questions asked participants to

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[177] Stinne Glasdam, Katharina Ó. Cathaoir, and Sigrid Stjernswärd, "Balancing Different Legal and Ethical Requirements in the Construction of Informed Consents in Qualitative International Collaborative Research Across Continents – Reflections From a Scandinavian Perspective," *Journal of Academic Ethics* 23, no. 2 (2025): 349–62, https://doi.org/10.1007/s10805-024-09536-5.

[178] Marilys Guillemin and Lynn Gillam, "Ethics, Reflexivity, and 'Ethically Important Moments' in Research," *Qualitative Inquiry* 10 (April 2004): 261–80, https://doi.org/10.1177/1077800403262360.

[179] Glasdam, Cathaoir, and Stjernswärd, "Balancing Different Legal."

reflect on potentially difficult experiences in CPE and clinical practice. The researcher monitored the emotional condition of the participants during the interviews, provided opportunities for breaks or the option to omit questions, and furnished information about available support resources as necessary. This concern for participant well-being is an example of what has been termed 'situational ethics' in qualitative research, attending to the dynamic context of the interview and responding to participants' needs as they arise.[180]

Power dynamics between researcher and participant were attended throughout the research process. The IPA's emphasis on treating participants as experts in their own lived experiences helped to mitigate power imbalances. The semi-structured interview format also enabled participants to lead the conversation and introduce topics they considered significant. This approach is consistent with "relational ethics," which emphasize treating participants with respect and attending to the quality of the researcher/participant relationship.[181]

Data security was ensured by storing digital files in password-protected, encrypted formats and securely transmitting the files. Audio recordings will be deleted at the end of the study. Pseudonymized transcripts will be retained for analysis and, with participants' explicit consent, may be kept for possible future use. All data handling procedures complied with relevant data protection regulations and institutional policies.

Regarding institutional approval, before the start of data collection, this study was submitted to the Institutional Review Board (IRB) at the University of the West for

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[180] Anne-Marie Reid et al., "Ethical Dilemmas and Reflexivity in Qualitative Research," *Perspectives on Medical Education* 7, no. 2 (2018): 69–75, https://doi.org/10.1007/s40037-018-0412-2.

[181] Reid et al., "Ethical Dilemmas."

ethical review and approval (see Appendix J: IRB Approval). The IRB submission package included the full research protocol, participant information and informed consent materials, the questionnaire, the semi-structured interview guide, and all documents related to participant recruitment. In accordance with institutional requirements for the protection of human subjects and established ethical guidance for research involving human participants, data collection began only after written confirmation of full IRB approval had been obtained.

Chapter Four:

Findings

Chapter Overview and Structure

This chapter presents the interpretative phenomenological analysis of seven Buddhist monastics' lived experiences of CPE. Following the methodological commitments of IPA, the findings are organized to honor both the idiographic particularity of each participant's account and the shared patterns that emerge across cases.[182] This dual focus reflects IPA's fundamental concern with understanding how individuals make sense of significant life experiences while also identifying themes that illuminate common dimensions of a phenomenon.[183]

The chapter is structured in three main sections. The first section presents idiographic findings through detailed case-by-case analysis of each participant. Following Smith, Flowers, and Larkin's guidance that the analytic process in IPA begins with a detailed examination of each case before moving to a search for patterns across cases, I provide individual narrative accounts for John, Dora, Hope, Faye, Lynn, Wynn, and Mona.[184] Each case study includes participant background and context, followed by exploration of the personal experiential themes that emerged from that individual's account. This idiographic approach ensures that each participant's unique voice and

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[182] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 79.

[183] Virginia Eatough and Jonathan A. Smith, "Interpretative Phenomenological Analysis," in *The SAGE Handbook of Qualitative Research in Psychology*, eds. C. Willig and W. Stainton Rogers (London: SAGE Publications, 2017), 193–211.

[184] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 38.

meaning-making are preserved before any cross-case synthesis is attempted.[185] Each case is summarized in its section, and a table is provided for each participant with their personal experiential themes. The tabular form provides the readers with a general review of the thematic architecture.

The second section presents a cross-case analysis that identifies patterns of convergence and divergence among the seven participants. Following the analytic strategies outlined by Smith, Flowers, and Larkin, I examine how themes from individual cases illuminate one another, where participants share common experiences, and where their experiences diverge in ways that reveal important dimensions of the phenomenon.[186] Six superordinate themes emerged from this cross-case analysis: (1) the negotiation of dual identities, (2) the transformation of emotional awareness, (3) the application and adaptation of Buddhist concepts in clinical contexts, (4) the navigation of cultural and religious difference, (5) the distinctive contributions of Buddhist monastics to chaplaincy, and (6) the vision for Buddhist chaplaincy training.

This section further presents a systematic summary of emerging themes, including a comprehensive cross-case table showing the distribution of themes across participants and a summary table of thematic distribution that highlights each participant's unique contributions. These tables serve both as a reference for readers and as a demonstration of how the analysis moved from individual accounts to shared patterns.

The third section maps the findings directly to the three research questions guiding this study, providing a structured overview of how participants' experiences

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[185] Noon, "Interpretive Phenomenological Analysis," 78.

[186] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 101–105.

address each question. This mapping illustrates the study's coherence and guarantees a clear connection between the findings and the study's objectives.

This chapter provides voice to the participants through the extensive use of extracts from interviews. Yardley stresses the importance of using participants' own words, being aware of context, and keeping analysis close to the lived experience under study.[187] Accordingly, this study draws heavily on interview data, incorporating both verbatim quotations and paraphrased or descriptive references to participants' accounts. In the text, participants are identified using pseudonyms (e.g., John). For any interview-based reference—whether a direct quotation or a paraphrase/summary—the accompanying citation uses an anonymous abbreviation/initial corresponding to that pseudonym (e.g., J) together with a timestamp range indicating where the relevant segment appears in the interview recording and transcript (e.g., J 10:05–10:19). These time-stamp ranges match those indicated in the transcription file.

The structure of this chapter—moving from the particular to the shared, from individual narratives to cross-case themes—reflects IPA's commitment to both idiography and the identification of meaningful patterns.[188] This chapter offers a detailed and complex description of the phenomenon under investigation while respecting the individual experiences of each participant and highlighting shared struggles and resources that influence Buddhist monastic involvement in CPE.

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[187] Lucy Yardley, "Demonstrating Validity in Qualitative Psychology," in *Qualitative Psychology: A Practical Guide to Research Methods*, ed. Jonathan A. Smith (London: SAGE Publications, 2008), 235–51.

[188] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 107.

Idiographic Findings: Case-by-Case Analysis

Case 1: John – Living the Dharma

Participant Background and Context

John is a retired infectious disease epidemiologist who spent nearly 40 years in California public health. Although he had practiced Buddhism since his teenage years, it was only after retiring that he moved to India and dedicated nearly three years to intensive Buddhist studies. There, he was ordained as a Tibetan Buddhist monk in the Geluk and Nyingma traditions, receiving the name Lobsang Yonten. Rather than remaining in a monastic setting in India, he felt called to hospital chaplaincy, particularly hospice and intensive care work (J 0:48–2:22).

Back in North America, John entered the Buddhist chaplaincy program at Emmanuel College, University of Toronto. At the time he began CPE, John was in his late sixties, considerably older than most of his cohort. From 2017 to 2018, he completed four units of CPE at UCSF Medical Center in San Francisco, working primarily in the pediatric oncology and bone marrow transplant units at Benioff Children's Hospital while also serving adult patients during on-call rotations (J 3:18–4:44).

At the time of the interview, he was working as a chaplain at St. Michael's Hospital in Toronto, a Catholic Level I trauma center, while pursuing a Doctor of Ministry degree at Regis College. His research focuses on how chaplains can better support hospital staff in palliative and intensive care units, who frequently confront death (J 4:46–5:24, 26:31–27:54). What makes John's narrative particularly compelling is the way he articulates how he sought and received approval from his Tibetan teachers for this

nontraditional path. As he explained, Tibetans generally do not understand the concept of a hospital chaplain, since it is not a recognized role in their culture. Yet after he clarified his motivations, his teachers affirmed that "what you're doing is living the Dharma" (J 1:48–2:04). That endorsement became foundational to his identity as a Buddhist monastic chaplain. Moreover, as a white man with decades of professional experience in healthcare, John is able to navigate clinical settings with ease and perform strongly in his chaplaincy role.

The Integration of Monastic Identity and Chaplaincy Practice

Living the Dharma Through Clinical Service

John's story always shows a seamless integration of his Buddhist monastic identity and his chaplaincy work. When asked about any difference or contradiction between being a monk and a spiritual caregiver, he answered without hesitation: "Absolutely none" (J 13:01). This integration was based on the basic Buddhist principles of compassion and wisdom:

> I think that the primary responsibility of a caregiver is compassion, which is one of the fundamental underpinnings of Buddhism, and ultimate compassion to take away suffering from people, if you can. And the other thing, frankly, in terms of wisdom, is the interconnectedness of all people, so I don't think there's any contradiction between being the Buddhist caregiver and Buddhist chaplain and what I do as a Buddhist monk; if anything, I think it helps. (J 13:01–13:48)

For John, the hospital setting became a direct arena for practicing the Dharma rather than an alternative to traditional monastic practice. He framed his approach as a Mahāyāna and Vajrayāna perspective, suggesting that helping someone at the moment of death represents one of the most appropriate expressions of Buddhist practice (J 25:13–26:29). He contrasted the "indirect benefit" of monastery-based meditation and chanting

with the "absolute direct benefit" observable in clinical encounters: "You can see people at peace… when somebody… says, 'Well, thank you! You know, you've made a difference in my thinking; you've made a difference in my life.' I mean, that's what it's all about" (J 25:44–26:29).

The Western Monastic Context and Its Implications

John's situation as a Western Buddhist monastic living outside traditional community structures presented both opportunities and challenges. He admitted that for many in the West, "a lot of us don't live in community," and unlike his experience in India, he now lives on his own (J 8:52–10:19). This made it possible for him to do his chaplaincy work, living near the hospital and working odd shifts, without monastic responsibilities interfering with clinical duties.

But John also knew that "not being in community requires a certain amount of extra discipline… to meet my responsibilities as a monastic" (J 10:05–10:19). This reflection suggests that there is an internal negotiation between maintaining a monastic identity and adjusting to a context that lacks the external supports of a traditional monastic structure.

He compared his situation to a Zen monastic in his CPE cohort who had to be present at her monastery for community responsibilities that conflicted with on-call responsibilities (J 11:16–12:45). This comparison revealed John's relative freedom but also the potential tensions between traditional monastic expectations and the requirements of CPE training—tensions he was lucky to avoid but which he recognized as real challenges for some monastics.

The Intersection of Buddhist Teachings and Clinical Realities

The Limitations of Karmic Explanations

Perhaps the most powerful part of John's narrative was his honest grappling at the interface of Buddhist ideas such as karma and clinical reality. He distinguished between intellectual understanding and visceral, real-world application:

> Karma says that bad things are happening because of… I mean, this is a tricky, or a two-second explanation. Bad things happen in this life because of things that you did in previous lifetimes. You can't tell that to a mother who has a three-year-old child who's dying from brain cancer. You can't tell that to a husband whose wife, who is the mother of a child, is dying because of breast cancer. You just can't do that. (J 15:59–16:48)

John likened it to the Christian concept of theodicy, stating that it is equally unsuitable to provide theological justifications for suffering in the context of pastoral care (J 16:48–17:05). This reflection revealed a sophisticated understanding of spiritual care that was distinct from religious instruction, an understanding that CPE itself reinforced.

What emerged from this tension was John's embrace of presence as the primary response to suffering. He noted that "one of the things we learn in CPE… is sometimes that there's just no answer to why something happens. So, you just have to sit there and be with someone in their pain and their suffering" (J 17:20–17:42). This insight connected directly to his Buddhist practice while also reflecting core CPE learning about the ministry of presence.

From Fixing to Being

John's previous career as an infectious disease epidemiologist shaped his initial approach to problems: "For years and years and years, you know, you're presented with a problem, you try and fix it" (J 19:08–19:17). The transition to chaplaincy required a

fundamental reorientation: “You can’t always fix these things. When you’re a chaplain, when you’re a spiritual care provider, you can just be with it.”

He identified this as “the hardest thing for me to learn” (J 19:24–19:30), describing an ongoing internal struggle between his “Western North American desire to fix something” and “the Buddhist philosophy that the world is unfolding as it should be” (J 19:51–20:03). This formulation captured a profound cultural and philosophical negotiation within himself—one that he recognized as continuous with CPE learning.

The phrase “the world is unfolding as it should be” is notable for its resonance with Buddhist teachings on impermanence and acceptance yet is immediately qualified by John with active engagement: “We’re here to learn to live with it and work with it and be with it” (J 20:00–20:03). This suggested an understanding of Buddhist acceptance that does not imply passivity but rather a grounded presence in the face of what cannot be changed.

The CPE Experience as Buddhist Practice and Professional Formation

CPE as Validation of Buddhist Principles

Rather than experiencing tension between CPE learning and Buddhist teachings, John found that “what CPE allowed me to do was validate the kinds of things that I believe as a Buddhist” (J 8:28–8:43). This validation operated on multiple levels. First, his Buddhist understanding of compassion resonated with the focus of CPE on being with suffering. Second, the interdisciplinary cohort model exposed him to diverse spiritual perspectives that enriched rather than challenged his Buddhist identity.

The presence of six Buddhists in his fifteen-person cohort—including Tibetans, Zen practitioners, and a Shin Buddhist—created an unusually supportive environment (J

10:50–11:16). John recognized the situation as "wonderful" and atypical, noting that the interviewer was the only Buddhist in her cohort (J 11:08–11:16). This critical mass of Buddhist practitioners likely influenced his perception of the program's understanding and appreciation of his tradition.

Relational Learning Across Difference

John's relationships with his four CPE supervisors exemplified the kind of learning that occurs through exposure to diverse perspectives. He described them as "very, very different people, all four of them," from whom he "learned something a lot" (J 5:48–6:07). His relationship with his last supervisor, who died of bile duct cancer, was particularly meaningful; John called him "a friend and a mentor" (J 6:30–6:45), suggesting that supervisory relationships in CPE can transcend professional boundaries to be genuine, meaningful relationships.

His cohort relationships also endured beyond the program, with former colleagues maintaining contact through Zoom and WhatsApp "all over the world literally" (J 6:50–7:05). John's position as "by far the oldest person in the cohort" (J 7:05–7:10)—he turned seventy during the program—did not isolate him but rather contributed to what he described as "wonderful, wonderful experiences with these people" (J 7:15–7:20). This intergenerational learning environment apparently enriched rather than hindered his experience.

Spontaneous Ministry as Human Connection

When asked about clinical visits, John's response revealed how thoroughly CPE learning had integrated with his Buddhist understanding of interconnection: "You stop and you minister to anybody who needs help. And you don't do that as someone who's

been through CPE; you do that as a human being, you do that as a Buddhist, because we're all interconnected" (J 8:05–8:26). This statement dissolved any artificial boundary between professional chaplaincy skills and fundamental human responsiveness.

The incident he recalled—encountering an adult man sobbing in the hallway who had just received a cancer diagnosis (J 7:40–8:05)—illustrated how CPE training becomes embodied rather than merely procedural. The response was not driven by assignment or role but by recognition of shared humanity.

The Distinctive Contributions of Buddhist Chaplaincy

Buddhism and Interfaith Spiritual Care

John articulated a vision of chaplaincy that transcends religious particularity while being grounded in Buddhist principles. He noted that in his current hospital setting, chaplains serve "anybody, of any religion, or no religion at all. You're providing emotional and spiritual support, and not necessarily religious support" (J 21:10–21:45). This distinction between spiritual and religious support was central to his practice.

His approach to serving Indigenous patients exemplified this orientation: "I need to be able to serve them with respect to their traditions, in the same way that I would respect somebody who's a Christian or who's a Jehovah's Witness or who has no religion at all" (J 21:45–22:05). For John, Buddhist principles of compassion and interconnectedness did not require imposing Buddhist frameworks but rather supported respectful presence across traditions.

Foundational Principles for Buddhist Chaplaincy Training

When asked about developing chaplaincy training specifically for Buddhists—particularly in the Chinese context—John returned to foundational principles: "Go back

to the foundation, foundational principles, wisdom, and compassion. We're all interconnected, and nobody wants to suffer" (J 29:35–30:05). He suggested that connecting chaplaincy to the Four Noble Truths—understanding suffering, its causes, and its alleviation—would make the training "more meaningful for Buddhist chaplains to understand chaplaincy in that way as an expression of wisdom and expression of compassion" (J 30:40–31:10).

John also acknowledged the professional challenges facing Buddhist chaplains in North America, where chaplaincy historically developed within Christian contexts. He described the "Buddhist equivalency" process through the Association of Professional Chaplains as "a horrible kind of process… requiring hundreds and hundreds of pages of documentation" (J 36:31–37:20). This observation highlighted the institutional work still needed for full recognition of Buddhist chaplaincy as equivalent to other traditions.

The Unfinished Work of Staff Care

John's current doctoral research focuses on a dimension of chaplaincy he believes is underdeveloped: spiritual care for hospital staff, particularly those in palliative care and intensive care units who are "constantly being exposed to people in pain and people dying, and families in grief" (J 26:55–27:30). His identification of this gap—"I don't think we do that very well"—reflects both his clinical experience and his Buddhist orientation toward suffering wherever it appears.

This research direction also suggests how John continues to integrate his multiple identities: epidemiologist, Buddhist monk, chaplain, and now doctoral student. His concern for staff well-being extends the logic of compassion beyond the patient-family dyad to include all those touched by suffering in the healthcare setting.

Summary

John's narrative reveals a remarkable coherence between his Buddhist monastic identity and his chaplaincy practice. Rather than experiencing contradiction or requiring compartmentalization, he experiences his clinical work as "living the Dharma"—a formulation endorsed by his Tibetan teachers and validated through CPE. His Western monastic context, while requiring extra discipline, has facilitated rather than hindered this integration.

To help readers better understand the structure of John's personal experiential themes, the table below outlines the superordinate and subordinate themes emerging from the analysis of his interview responses and presents a clear, structured overview of the thematic framework that supports the narrative findings discussed in this section.

Table 3: John's Personal Experiential Themes

Superordinate Themes	**Subordinate Themes**
• The Integration of Monastic Identity and Chaplaincy Practice	• Living the Dharma Through Clinical Service • The Western Monastic Context and Its Implications
• The Intersection of Buddhist Teachings and Clinical Realities	• The Limitations of Karmic Explanations • From Fixing to Being
• The CPE Experience as Buddhist Practice and Professional Formation	• CPE as Validation of Buddhist Principles • Relational Learning Across Difference • Spontaneous Ministry as Human Connection
• The Distinctive Contributions of Buddhist Chaplaincy	• Buddhism and Interfaith Spiritual Care • Foundational Principles for Buddhist Chaplaincy Training • The Unfinished Work of Staff Care

The challenges John identifies are not between Buddhism and chaplaincy but within specific Buddhist teachings when confronted with clinical realities. His honest grappling with karma and suffering, and his insight that presence is often more important

than explanation, reveal a mature integration of intellectual understanding and visceral human response. His movement from "fixing" to "being" is a marker of personal development and is in keeping with the fundamental principles of Buddhism and CPE.

Thus, John's vision of Buddhist chaplaincy focuses on core principles, not sectarian uniqueness. It proposes that wisdom and compassion, as articulated through frameworks like the Four Noble Truths, can offer a basis for chaplains working across traditions.[189] His ongoing doctoral research on staff care extends this vision to include all those affected by suffering in healthcare settings.

What emerges from John's account is a model of Buddhist monastic chaplaincy that is neither defensive nor assimilationist but confidently grounded in Buddhist principles while fully engaged with the interdisciplinary, interfaith reality of contemporary clinical settings. His experience suggests that for Buddhist monastics called to this work, CPE can serve not as a departure from monastic identity but as its lived expression.

Case 2: Dora – Discovering the Wall

Participant Background and Context

Dora is a Chinese Mahāyāna Buddhist nun from Fujian province, China. At the time of her interview, she was in her first year of the Doctor of Buddhist Ministry program at UWest and had completed one unit of CPE in the summer of 2019 at Bellevue Hospital in New York (D 0:02–1:13). Her decision to pursue CPE was initially prompted

[189] Trudi Jinpu Hirsch, "The 4 Noble Truths as a Framework for Contemplative Care," in *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*, ed. Cheryl A. Giles and Willa B. Miller (New York: Oxford University Press, 2015), 143–60.

by faculty encouragement rather than personal initiative—she acknowledged that without such encouragement, she "probably wouldn't do it because it takes a lot of courage" (D 1:13–1:30). Her admission of initial reluctance is a setup for a story of profound transformation.

Dora's CPE experience was distinctive in several ways. She was the only Buddhist in her cohort of six students, which included two Roman Catholics and one Reform Jew, with all peers being significantly younger—mostly in their mid-to-late twenties, while Dora was in her thirties (D 3:08–4:36). She worked with a supervisor in his sixties who had twenty years of experience as an educator, a relationship that would prove pivotal to her growth (D 6:13–7:10). Her clinical assignments included work with patients on various units, including a prison unit within Bellevue Hospital, exposing her to diverse populations, including mentally ill patients and homeless individuals (D 22:29–24:13, 33:01–35:10).

The Emotional Awakening of a Protected Self

Discovering the Wall

Perhaps the most profound theme in Dora's narrative is her discovery of what she metaphorically describes as "a wall" she had constructed to protect herself from emotions. This wall served a dual purpose: keeping her emotions contained and keeping others' emotions at a distance. The realization contrasted her young, emotionally expressive peers:

> These emotional people cannot help me to find or discover my own emotions, because as a monastic we can keep our emotions away from people, but there they can… Their emotions, their story emotions, kind of opened my emotions up, and then I found how distant my… how I keep a wall; I build a wall to protect myself and the world. Because they don't have the wall that they reminded me of… Oh, I

> have a wall, you know, for myself, and I should turn it down in order to provide better help or in order to understand people better. (D 8:30–9:50)

This moment of self-discovery marks an important turning point in Dora's growth as a spiritual caregiver. The wall, which might have been for protection during monastic life, became an obstacle to the kind of presence required in clinical settings. Her peers' emotional availability served as a mirror, reflecting to her something she had not previously recognized about herself.

The Cultural and Monastic Conditioning of Emotion

Dora situated her relationship with emotion within multiple layers of conditioning: as a Chinese person, as an Asian, and as a monastic. She noted that in Chinese culture, "we are not supposed to express our emotions" (D 39:36–40:10). This cultural norm may be reinforced by the training of Buddhist monastics in emotional equanimity and non-attachment. Dora came to realize, however, that this conditioning made it difficult for her to stay fully present with patients' suffering:

> Because for me, because I guess… because of my own background, I always try to run away from my emotions because it's so difficult to stay there. And then it will turn out that it's difficult for me to stay with patients' emotions when they feel so sad, when they are kind of crying in great grief; then I try to run away. I try to change the subject to something happier, something positive. (D 11:09–12:10)

This candid self-reflection reveals Dora's heightened awareness that her instinctive reaction to intense emotion—her own and that of others alike—was to withdraw. The clinical setting demanded something different: the capacity to "bear with it, you know, and stay with it; at least leave some space for the kind of emotion" (D 12:30–12:50). This tension between monastic-cultural conditioning and clinical requirements became a central focus of her learning.

The Transformation Through Emotional Exposure

Despite the discomfort, Dora came to value what her emotional peers offered her. Their presence in her life created opportunities for emotional learning that she recognized as lacking in her previous experience:

> I feel I lack… in my life because as an Asian, a Chinese Asian, as a Chinese, I grew up in that kind of culture. We are not supposed to express our emotions. So being in the hospital and kind of discovering my own emotional realm… So, it's like, then this really helped me to… When I left the hospital, I came back to the temple, when I… so the skill is still there; I can have more connection with the monastics in my life and the laypeople and even people who are… You know, that I encountered, because these people all have emotions. (D 39:36–40:35)

The phrase "the skill is still there" is significant—it suggests that emotional awareness and presence became an enduring competency she carried back into her monastic life. This transfer of learning from clinical to monastic contexts represents one of the most valuable outcomes of her CPE experience.

The Negotiation of Monastic Identity in Clinical Space

The Robe as Skin

Dora's struggle over whether to wear her monastic robe in the hospital became a powerful symbol of the negotiation between her monastic identity and her emerging chaplain identity. Initially, she received permission from her supervisor to wear the robe and firmly maintained that position. When the supervisor suggested she try wearing secular clothes and asked, "Do you want to try to wear normal clothes?" she initially refused (D 19:10–20:30).

Her description of the robe as "my skin" (D 21:02) powerfully conveys how deeply her monastic identity was embodied. Take off the robe, and you take off a layer of yourself: "I feel uncomfortable when I don't wear the robe" (D 21:02–21:10). This

physiological response is evidence that the robe was not simply clothing for Dora but an extension of her monastic self, a source of comfort and protection.

Her supervisor's gentle challenge—"your robe is not you"—initially met with resistance ("No, my robe is me!"). But it planted a seed that later prompted reflection and, after consulting a senior temple member, a willingness to experiment (D 20:30–21:30). This process of consultation with her monastic superior is important, because it shows how Dora is working through the tension of clinical expectations and monastic authority, seeking permission to adapt but still rooted in her tradition.

The Vulnerability of Unrobed Presence

Dora's experiment with wearing secular clothes in the hospital revealed the protective function the robe had served. Without it, she felt exposed and less effective:

> When I take off my robe, I feel like maybe, you know, I do a worse job because people respect me less. Maybe this is just a feeling; it's not true, but I have this kind of feeling because I don't feel comfortable without my robe. (D 22:29–23:00)

Her supervisor's intention, she came to understand, was to make her life "more difficult" by removing the comfort of the robe—not to be cruel, but to push her growth (D 22:00–22:29). The robe provided a recognizable religious identity that commanded certain responses, as illustrated by the striking incident in the prison unit where a man bowed to her, dropping to his knees (D 23:00–24:00). While such recognition might feel validating, her supervisor recognized that over-reliance on the robe's protective and authority-conferring functions could limit her development as a chaplain who must meet patients as they are, without the buffer of religious garb.

Boundaries with Male Patients

Dora's relationship with male patients represents yet another dimension of how she negotiated monastic identity. The hospital posed a new challenge for Dora, who came from a monastic context with limited interaction with men.

> The man, especially a lot of men… We meet different men every day. This is very different from the monastic life that I had in school and temples. I think this is the one challenge because we kind of isolate our lives from, you know, the men. And then, so it's like now we have to have, you know, some kind of relationship with them. It's like, then I have to adjust myself to have a proper relationship with them, so what kind of boundary should I build? (D 12:30–13:40)

This challenge became concrete when patients made comments like "Oh, I like you very much!" or "Oh, I love you!"—situations for which her monastic training had not prepared her (D 13:40–13:56). Her response of falling "shut and quiet" suggests a lack of strategies for negotiating the interpersonal dynamics of this situation in a way that honors boundaries. This aspect of her story exemplifies how CPE situates monastic students in relational settings that are far removed from the regulated and often single-sex environments of monasteries and temples.

The Integration of Buddhist Frameworks in Clinical Practice

The Three Tenets of Zen Peacemakers

When asked about Buddhist concepts she applied in her clinical practice, Dora immediately identified the Three Tenets of the Zen Peacemakers: Not Knowing, Bearing Witness, and Loving Actions (D 28:07–28:30). These became her conceptual framework for writing evaluations and, more importantly, for approaching patients:

> These three tenets, I think that they are very important for me to learn, to enter a room without… Put my own thinking idea away, and just before entering the room, this is an attitude that I love. (D 28:07–28:50)

The tenet of "not knowing" resonated with Dora's need to set aside preconceptions and be present to whatever arose in the clinical encounter. However, she also acknowledged the challenge of communicating such concepts to her peers: "I didn't feel I was successful. I guess they didn't understand it… They never have this kind of training; it's okay. Even they don't understand that well." (D 29:00–29:50) This difficulty in translating Buddhist frameworks for interfaith peers represents a common challenge for Buddhist CPE students in predominantly non-Buddhist settings.

The Four Noble Truths as Clinical Framework

Dora also applied the Four Noble Truths to her clinical understanding, particularly the reality of suffering and the possibility of its cessation:

> I also use the Four Noble Truths. It's like the suffering and how to solve the… not solve the problem, but how to deal with it. People suffering, the end of suffering, suffering, and the end of suffering. So, because there is a lot of suffering in every room, there is physical and emotional discomfort. So, it's like, how can I release… reduce their suffering? This is, like… kind of one of my goals. Even sometimes I probably don't know how to provide, you know, the method to end their suffering, but being there is kind of one way to reduce their suffering. (D 30:10–31:20)

Dora performs the sophisticated integration of Buddhist philosophy and clinical chaplaincy. She recognizes that the "method" to end suffering may not always be available, but presence itself becomes a means of reducing suffering—an insight that bridges Buddhist understanding and CPE learning about the ministry of presence.

Emptiness and Existence in Clinical Perception

When asked specifically about emptiness (*śūnyatā*), Dora offered an honest reflection on the difficulty of applying this concept clinically:

> I kind of focus on existence, because suffering is kind of existence, but emptiness is difficult to focus on. Of course, impermanence, I can do… I can focus like

> people come and leave and people die; yeah, a lot of dead people. I've seen some dead bodies too. (D 37:00–38:00)

This acknowledgment that emptiness recedes from clinical awareness while suffering and impermanence remain vividly present speaks to the phenomenological reality of hospital chaplaincy. The sheer concreteness of suffering—homeless patients who "smell very badly," mentally ill individuals trapped in their own worlds, stressed staff with no time for self-care—makes abstract philosophical concepts like emptiness difficult to hold in awareness (D 33:01–37:00). Yet Dora's very recognition of this difficulty represents a form of wisdom.

The Transformative Learning Through CPE

From Nervousness to Self-Awareness

Dora repeatedly described herself as "a nervous person," particularly in new environments (D 6:13–6:30). Her CPE experience did not eliminate this nervousness but gave her tools to work with it: "As long as it goes and I feel less and less nervous, even if I still feel nervous, I feel like I can deal with my nervousness" (D 6:30–6:50). It's a big step from someone being overwhelmed with nervousness to being able to handle it.

The structure of CPE with its mix of clinical exposure, reflective writing, and group processing provided the container for this growth. Her supervisor played a big role, "push[ing] me very hard" in unexpected ways, pointing out things she didn't know about herself (D 7:00–7:30). Her response was ambivalent: "I didn't like it, but I really appreciated him." This statement speaks to the challenging, yet valued, nature of this supervisory relationship.

Learning to Listen

Listening was the first of the skills Dora developed. She described a fundamental shift in her approach to communication:

> I learned to listen… Oh, maybe I should listen first before I react, before I want to say something, because sometimes whatever I say is not helpful. Well, sometimes when I say I just want to express what I want to say, but it might not be what they want to listen to. So, this is very important for me to learn and practice in my life. (D 40:35–41:20)

This learning extended beyond clinical encounters to her monastic life, improving relationships with other monastics and lay people. The statement "I become a better listener" (D 40:35) suggests a continuing capacity beyond the CPE program itself.

Communication Skills and Conflict Resolution

Dora also reported improvements in her general communication, especially in relation to conflict:

> Even sometimes when I have conflicts with people, I will reflect on myself and how to communicate better. So, communication skills are another thing that I love that I learned from this program, and I kind of apply them in my own life. (D 41:20–42:00)

This transfer of learning from clinical to personal contexts represents one of the most valuable outcomes of CPE for monastic students. The skills of reflective practice, self-awareness, and interpersonal communication learned in CPE have applications well beyond the hospital setting.

The Distinctive Position of the Buddhist Monastic in CPE

Advantages of Monastic Formation

But despite the challenges she faced, Dora could see several benefits from her monastic background in CPE. First was a sense of groundedness and calm, even amid

nervousness: “Compared to my peers, maybe they don’t look nervous, but you know, they are very emotional, but for me, even if I’m nervous and I’m kind of emotional in another way, still, like, I would not be affected too much by them” (D 17:02–18:00).

Second was the support of her religious practice: taking refuge in the Three Jewels, participating in morning chanting and Dharma events at the temple where she stayed, and studying Dharma theory in the evenings (D 18:00–19:00). This ongoing religious life provided a container that helped her process the intensity of clinical exposure.

Third was what she perceived as greater focus and clarity of purpose compared to some peers who brought “a lot of unsolved problems” into the program:

> I have one purpose… I want to learn; I want to get benefits from this CPE program experience. But for my peers, I realized they have a lot of stories before they come here; you know, they have a lot of unsolved problems before they come to this program. So, they cannot really participate one hundred percent in this program. (D 19:00–20:00)

This observation suggests that Dora saw her monastic formation as providing a kind of emotional and psychological stability that allowed her to engage more fully with the learning opportunities CPE offered.

Language and Cultural Challenges

Dora’s obstacles were significant and multiple. English was a constant challenge, especially medical terminology: “There are a lot of new words in the hospital that I don’t know, like what kind of disease, you know, the names of the diseases and also like the new vocabulary in the hospital setting” (D 10:20–11:00). This linguistic barrier compounded her nervousness and created worry about her ability to understand patients and thus help them.

She developed strategies to work around this limitation: trying to understand patients' feelings even when she couldn't catch all their words, using computers to research patients' situations, and speaking with others to gather information (D 11:00–12:00). Her approach reflects a practical acceptance of limitations and creative problem-solving—as she puts it, "I try to avoid my weakness, because I couldn't do anything" (D 11:29–11:35).

The Challenge of Asian Patients

A particularly nuanced challenge emerged in Dora's visits with Asian patients, who often resisted her overtures:

> When I was in the hospital, I tried to visit Asian patients. I find it difficult to talk about emotions with them. And I find that they kind of refuse to see me, because they see me… because I guess they are not familiar with chaplains. So, when they see me, it's like, "Who are you? You're a stranger. I don't want to tell you my suffering. No, no, no." (D 14:53–15:50)

This resistance highlighted the cultural specificity of chaplaincy as a North American institution. In contexts where chaplains are unknown, even a co-ethnic visitor may be perceived as an intruder rather than a resource. Dora's reflection on this challenge—"I'm not sure about Asians… because the Asian culture is different"—shows her awareness that the models of spiritual care she was learning might need adaptation for Asian cultural contexts.

Vision for Buddhist Chaplaincy Development

Essential Buddhist Frameworks for Training

When asked what Buddhist principles and frameworks should be included in clinical training for Buddhist chaplains, Dora identified several elements. The Three

Tenets of Zen Peacemakers and the Four Noble Truths were primary (D 1:52–2:30). She also emphasized meditation techniques:

> Kind of meditation techniques, like loving-kindness and even breath and body scan, these different kinds of meditation… I try to collect the different kinds of resources for meditation and meditation skills; for example, I, you know, find, like, a meditation for reducing pain. So, actually people can use meditation to reduce the patient's pain. And this is very helpful. (D 2:30–3:30)

The specificity of her suggestion—meditation for pain, for anger, for relationships—reflects her recognition that different clinical situations call for different spiritual resources. Meditation became not only her own practice but also a tool she could offer to receptive patients.

Group Facilitation Skills

Dora also pointed to the value of learning how to facilitate groups, based on her training in the Way of Council and chaplaincy club experiences:

> The skills that I learned from there, and also in the chaplaincy club, you know, are how to run a group for the patients and maybe also the nurses. So, this is very important: to bring people together. And how to bring people together and let them talk? You know, you don't need to really talk too much… you need to know how to make them talk and how to make them learn from each other. (D 3:30–4:37)

This emphasis on group facilitation reflects Dora's understanding that chaplaincy extends beyond one-on-one encounters to include building communities of mutual support. This skill is particularly relevant in Buddhist contexts, where the Sangha (community) is one of the Three Jewels.

Learning to Pray Across Traditions

Another skill Dora developed through CPE was the ability to offer prayer in an interfaith context. She recounted an experience at the temple where she was staying when

an Asian man came asking for prayer and was turned away with "We don't have this kind of service" (D 24:53–27:00). Dora recognized this as a missed opportunity:

> For me, I feel like, oh, you know, I know how to offer, how to pray for him in a kind of interfaith way. Because I have learned in the CPE program. Even though I didn't do it, I know how to do it. So, this is like something that I love. And I think I can do it in the future for my own temple. (D 26:00–27:00)

This learning—how to create Buddhist prayers responsive to people's needs even when those people are not Buddhist—represents an innovation in traditional Buddhist practice that CPE made possible.

The Question of Emotion in Asian Contexts

Dora offered a significant insight regarding the development of Buddhist chaplaincy in Asia: the need to address emotional awareness in training. She noted that Asian cultural norms around emotional expression might create similar challenges for Asian Buddhist chaplains as she herself experienced:

> Because this is something we can do in the training program, develop our emotions and other people's emotions, and try to stay with it. Because for me, because I guess, because of my own background, I always try to run away from my emotions… And then it will turn out that it's difficult for me to stay with patients' emotions. (D 11:09–12:10)

Her recognition of the possibility that "emotion might be important" in training in China, given the shared Asian cultural patterns, reveals a nuanced view of the need to culturally adapt Buddhist chaplaincy education, while also raising questions about some cultural norms that may impede proper spiritual care.

Summary

Dora's narrative follows a path from nervousness and reluctance to a profound personal discovery and a vision for a transformed Buddhist ministry. Her time at

Bellevue Hospital's CPE was a crucible that tested and reshaped her assumptions about herself, her feelings, and her monastic identity. The table below describes superordinate and subordinate themes emerging from Dora's interview data. It offers a lucid and methodical synopsis of the thematic matrix that underpins her narrative.

Table 4: Dora's Personal Experiential Themes

Superordinate Themes	Subordinate Themes
• The Emotional Awakening of a Protected Self	• Discovering the Wall • The Cultural and Monastic Conditioning of Emotion • The Transformation Through Emotional Exposure
• The Negotiation of Monastic Identity in Clinical Space	• The Robe as Skin • The Vulnerability of Unrobed Presence • Boundaries with Male Patients
• The Integration of Buddhist Frameworks in Clinical Practice	• The Three Tenets of Zen Peacemakers • The Four Noble Truths as Clinical Framework • Emptiness and Existence in Clinical Perception
• The Transformative Learning Through CPE	• From Nervousness to Self-Awareness • Learning to Listen • Communication Skills and Conflict Resolution
• The Distinctive Position of the Buddhist Monastic in CPE	• Advantages of Monastic Formation • Language and Cultural Challenges • The Challenge of Asian Patients
• Vision for Buddhist Chaplaincy Development	• Essential Buddhist Frameworks for Training • Group Facilitation Skills • Learning to Pray Across Traditions • The Question of Emotion in Asian Contexts

The central theme of her narrative is the discovery and partial demolition of the emotional 'wall' she had built up, a wall reinforced by Chinese cultural norms and monastic training. When Dora met emotionally expressive peers, faced the challenge of her supervisor, and saw the raw suffering of patients, including the mentally ill and homeless, she saw that her protective strategies, while useful, limited her ability to be truly present with suffering people.

Her struggle over wearing the robe symbolized the deeper negotiation between her identity as a Buddhist monastic and her identity as a chaplain. The robe, like a "skin," gave her comfort and recognition, but also shielded her from the vulnerability required for authentic encounter. Her supervisor's insistence that she wear secular clothes, though uncomfortable, pushed her to grow.

Dora's application of Buddhist frameworks—particularly the Three Tenets of Zen Peacemakers and the Four Noble Truths—exemplifies her integration of traditional teachings with clinical training. At the same time, her candid admission captures the phenomenological reality of hospital chaplaincy: that the notion of emptiness often recedes from clinical awareness, while suffering remains vividly present.

The skills Dora developed—listening, emotional presence, communication, group facilitation, interfaith prayer—extend beyond clinical settings into her monastic life. Her vision for future training in Buddhist chaplaincy, stressing emotional awareness and meditation skills geared to specific needs, represents an integration of her CPE learning with her ongoing commitment to Buddhist practice and ministry.

Most importantly, Dora's story suggests that for Buddhist monastics, CPE can be both a professional training and a personal transformation—an opportunity to discover aspects of self that monastic and cultural conditioning may have hidden and to develop capacities for presence and connection that enrich both clinical work and religious life.

Case 3: Hope – Multifaith as Liberation

Participant Background and Context

Hope is a Vietnamese nun in the Northern Transmission tradition. Her path to CPE was shaped by prior graduate education and clinical training: She completed a Master of Divinity (MDiv) program followed by a Marriage and Family Therapy (MFT) program with its associated internship (H 0:15–0:52). Her decision to pursue CPE came after completing these earlier programs, driven by curiosity about how chaplaincy would differ from her therapeutic work: "I just wanted to take the opportunity this summer to do it, to do it and try CPE and see how it is different from Marriage and Family Therapy" (H 0:15–0:52).

Hope completed her CPE unit at Cedars-Sinai Medical Center in Los Angeles, a program she identifies as distinctive for its multifaith rather than interfaith approach. Her interview took place the day after her program ended ("It just ended yesterday; we had our final evaluations and whatnot"), placing her reflections in the immediacy of completion (H 3:09–3:30). Her prior clinical experience in MFT provided a foundation of comfort with patients across the diagnostic spectrum, including those with schizoaffective disorder, panic disorder, anxiety, and depression (H 5:45–6:30).

What distinguishes Hope's narrative is her sophisticated critique of the power dynamics embedded in chaplaincy training and her vision for Buddhist collective action to transform these structures. Her experience at Cedars-Sinai—which she describes as exceptionally accepting of her full monastic identity—nevertheless revealed to her the limitations of a system still shaped by Christian assumptions and practices. This awareness, combined with her double training in therapy and chaplaincy, makes her both

an insider who has "made it" within those structures and a critic who dreams of something radically different.

The Multifaith Framework as Liberation

Interfaith vs. Multifaith Distinction

Hope's narrative begins with a crucial distinction that shaped her entire CPE experience: the difference between interfaith and multifaith approaches. At Cedars-Sinai, she explains, the program is "multifaith instead of interfaith," a distinction she elaborates with precision:

> What it does is that it respects, you know, the chaplain's religion of origin. And it doesn't ask, you know, us to be in a different role where we have to compromise our religious standing or our understanding of our background. (H 1:37–2:20)

The multifaith model, as Hope describes it, does not require chaplains to adopt a generic spiritual identity or to water down their tradition to discover common ground. Instead, it honors the particularity of each chaplain's religious identity while creating structures for collaboration. When a patient's needs fall outside a chaplain's comfort zone or competence, "there are plenty of other chaplains, you know, interns and full-time staff chaplains, that can do that job, and so when you can, just refer out" (H 2:20–2:52). Hope identifies this system of referral, which is based on authentic religious identity rather than the expectation of universal adaptability, as "the beauty of Cedar-Sinai's CPE program" (H 2:52–3:00).

This distinction is more than semantic for Hope—it represents a fundamental orientation to religious difference that allowed her to practice with integrity. The multifaith framework provided space for Hope's full Buddhist identity to be not only

tolerated but valued, especially in a field where Buddhist chaplains often navigate programs designed around Christian assumptions.

The Robe as Authority

The practical outworking of Cedars-Sinai's multifaith commitment is evident in Hope's ability to wear her full traditional robes. This freedom was not merely permitted but "encouraged" (H 10:20–10:30). Hope experiences her robes not as a costume but as an embodiment of "full Buddhist monastic authority" (H 10:10–10:20). The contrast with settings where Buddhist monastics are asked to modify or abandon their robes is implicit but significant.

For Hope, the robe serves multiple functions. It is a marker of identity that invites curiosity from open patients: "Tell me more about your robe and what you do, you know, your tradition and things like that" (H 11:10–11:30). At the same time, it can trigger resistance from patients who assume that any visibly religious figure, particularly one from an unfamiliar tradition, must be there to proselytize: "when they see me in the traditional robe, they just shut me out right away" (H 6:30–7:00).

This dual response—curiosity from some, rejection from others—becomes a reality of Hope's clinical presence. The robe, while authentic to her identity, is not neutral; it carries meaning that she must navigate in each encounter. Yet the freedom to wear it and to be received (or rejected) as a fully embodied Buddhist monastic is essential to her sense of integrity in the work.

The Integration of Therapeutic and Buddhist Frameworks

Clinical Confidence from Prior Training

Hope's prior training in MFT provides a foundation of clinical confidence that distinguishes her CPE experience from that of students without such a background. She describes herself as "very comfortable and very confident" in patient visits, with the caveat that "there's a factor of unknown" that keeps her grounded and attentive (H 7:30–8:10).

This confidence manifests in her ability to work across the full range of patient populations and conditions. She connects with patients of all religious backgrounds—Muslims, Catholics, Baptists, Jews, and the spiritual-but-not-religious—and attributes this capacity in part to her Buddhist formation: "Because of our Buddhist background, we can connect to patients of all religions, because of our, you know, our religious values and beliefs" (H 3:30–4:30). The phrase "It's a way of life" suggests that Buddhism, for Hope, provides not a set of propositions to be asserted but an orientation that can be lived in diverse contexts.

The integration of therapeutic and Buddhist frameworks is evident in her description of what she offers: "compassionate action in my service" (H 4:30–4:50). This phrase bridges the clinical language of service with the Buddhist language of compassion, suggesting a seamless integration of her multiple formations.

The Challenge of Translating Buddhist Concepts

Despite her confidence, Hope encounters the ongoing challenge of translating Buddhist concepts for patients and colleagues. Her cohort members, initially unfamiliar with Buddhist terminology, became learners who by the end of the program "were

regurgitating some things that I spoke about, you know, some Buddhist philosophies" (H 5:10–5:30). This delighted surprise—"I was shocked, oh, you have to remember that, okay"—reflects both the rarity of such learning and Hope's pleasure at being heard.

With patients, translation becomes more delicate. Hope adapts her language to each person's receptivity, sometimes avoiding Buddhist terminology altogether while still conveying Buddhist insights. Meditation, for example, may be offered as "visualization" or "deep breathing" when patients might be defensive about the word "meditation" (H 32:20–32:43). This flexibility reflects not compromise but skillful means—the Buddhist concept of *upāya*—applied in a clinical context.

The Case of the Positivity Patient

Hope's narrative reaches a pivotal moment when a patient faces a challenge to her faith in positive thinking due to the progression of her cancer. When she experienced a religious crisis because "the power of positivity cannot cure her cancer," Hope responded from what she understood as a Buddhist perspective aligned with scientific realism:

> I validated her pain, her crisis; I said, of course, you know, it's impossible. This is a physical reaction from your body; this is that deep down at a genetic level, right? So just think what you can, you know, and you can be positive at some point, but it doesn't create miracles, you know, and you still have to accept your body's condition. (H 12:30–13:30)

This response, which Hope saw as validating the patient's experience while gently challenging an unsustainable belief, received negative feedback from her supervisor. The concern was that Hope was "interjecting my religious belief" and potentially challenging rather than supporting the patient's spiritual crisis (H 13:30–14:10).

Hope's reflection on this feedback reveals her understanding of the tension:

> From the Buddhist background, we're, you know, we're in tune with the science; we're like, okay, you know, that's not very scientific, or, you know, you're not

> accepting of your current condition, you know, and because of that, it causes suffering, right? So that's very simple. It's in alignment very well. But that's also, on the other side, on the other hand, you know, how it goes. You know what? What I said went against her religious belief, and from an outsider's perspective, I was interjecting my religious beliefs, challenging her, and not addressing her spiritual crisis. (H 13:30–14:30)

This case illuminates a deep challenge for Buddhist chaplains working in multifaith contexts: how to offer the insights of one's tradition without imposing them on patients whose spiritual frameworks differ. Hope's supervisor's feedback indicates that a Christian patient may perceive what Hope considered compassionate realism as a threat to her faith. The fact that the patient was discharged before Hope could revisit the topic leaves the learning incomplete: "that area… will be left for other Buddhist monastics to discover" (H 14:30–14:43)—but the case itself becomes a rich site for reflection on the complexities of inter-religious spiritual care.

Buddhist Concepts in Clinical Practice

Thematic Application of Core Teachings

When asked about Buddhist concepts applied in her practice, Hope identifies several core themes. Impermanence emerges as particularly relevant: "the theme of impermanence, the theme of attachment, attachment to happiness instead of acknowledging the full range of our personality" (H 16:35–17:10). She observes how patients who focus only on positivity, avoiding the full range of human experience, suffer when positivity fails them.

She also teaches patients concrete practices for working with pain, drawing on meditation techniques:

> I teach them to do deep breathing. And then, you know, to observe the pain when it rises, you know, and then receive it, you know, just like a wave, you know, and

> just ride along with it; just do a visual, you know, a visual or mental surfing with, you know, surfing on the wave of the pain. (H 17:10–18:00)

This imagery of surfing the wave of pain translates Buddhist teachings on non-resistance and observation into accessible, non-religious language that patients can use regardless of their own beliefs.

Hope also references the Eightfold Path and the Six Harmonies (monastic harmonies) as frameworks that inform her interactions with others (H 18:00–19:00). While she rarely cites texts directly with patients, she uses stories and texts in self-reflection and group sharing, suggesting that Buddhist resources function differently in different contexts—sometimes as direct clinical tools, sometimes as personal grounding, sometimes as contributions to interfaith learning.

Translating Buddhist Language

Hope is attentive to the weight of words and adapts her language accordingly. She notes that "suffering" (*dukkha*) can feel heavy, so she might ask instead, "What is the issue that you're facing or something" (H 22:53–23:20). This linguistic sensitivity reflects awareness that the goal is not to teach Buddhist terminology but to convey Buddhist wisdom in forms patients can receive.

In one case, a patient experiencing shame and guilt about her illness blamed herself: "It's my fault. I did this upon myself." Hope responded by introducing impermanence: "Look, you know, it's maybe because you have these habits, but it's also that our body breaks down" (H 23:20–24:20). This approach offers a mild challenge to self-blame without dismissing the experience of the patient and extends the scope of understanding to include, but not limited to, personal responsibility.

Hope deconstructs the notion of emptiness (*śūnyatā*) into palatable parts: "No creator, no contributing, you know, person, and also there's no soul so that, you know, all of these are combinations, and because they're combinations, we are vulnerable to changes" (H 24:20–25:30). This formulation links emptiness to vulnerability and impermanence, making the abstract concept clinically relevant.

She concludes that "the topic of suffering, emptiness, and impermanence is addressed in, I think, every single patient that I have. It may be a combination of one of those three or all of those three" (H 25:30–25:52). This suggests that for Hope, Buddhist teachings are not optional additions to her clinical work but the very lens through which she perceives and responds to human need.

The Dual Experience of Visibility and Misperception

The Surprise of Open-Minded Tradition

Hope observes that her traditional appearance—the full monastic robe—often triggers assumptions that she will be rigid or unable to understand patients' perspectives. This becomes an opportunity for surprise and connection:

> They have a preconceived notion that we're traditional; we are traditional; we won't be able to understand, you know, where they're coming from, their viewpoints. And then, when they talk to us, they find out, or not to us, but to me, when they talk to me, they realize, "Wow, I am so wrong about you. You're so open-minded; the more you're open, you're more open-minded than I thought." (H 26:15–27:30)

Hope's reflection on this dynamic is complex: she considers her openness not as a break from her tradition but as an expression of it. "Being open-minded is also a path, a part of the monastic practice. So, in a way, I'm not doing anything that is… that challenges, you know, my faith or my beliefs" (H 27:30–28:00). The apparent paradox—

a traditional monastic who is unexpectedly open-minded—resolves when one understands that openness is itself a Buddhist value.

Misconceptions and Rejections

The same visibility that enables connection with open patients also invites rejection. Hope describes patients who, seeing her robe, "just say no, you know, I'm not interested in what you have to say, thinking that I am here going to proselytize or try to convert them" (H 6:00–6:30). The irony is palpable: a tradition that does not proselytize is rejected on the assumption that it will.

She also encounters overt racism, with patients reacting to "the way I look as an Asian" (H 6:30–7:00). These rejections are painful but become data for Hope's understanding of the challenges Buddhist chaplains face. Unlike chaplains from majority traditions, she must contend not only with religious misunderstanding but also with racial prejudice.

A particularly telling incident involves a family member who, seeing Hope approach, announced to the patient: "Oh, she's here to do religious guidance." When Hope clarified, "I don't give guidance. I'm just here to talk," the rejection stood (H 29:00–29:30). Hope's Buddhist approach does not fit the model of spiritual care that assumes a religious figure must be there to direct or guide, rather than to accompany.

The Kung Fu Question

With self-deprecating humor, Hope mentions a recurring question: "Do you do kung fu? You know, martial arts?" (H 28:30–29:00). This question reflects the cultural stereotypes that Asian religious figures, particularly those in robes, must navigate. While

amusing, it also represents the ongoing work of education and clarification that falls disproportionately on Buddhist chaplains from Asian backgrounds.

The Critique of Power and Vision for Transformation

The Proselytizing Encounter

A pivotal incident in Hope's narrative involves a patient's husband who, without asking permission, placed his hand on Hope's shoulder and began praying over her, asking God to "deliver her" or similar language (H 34:08–36:00). Hope's response reveals layers of complexity:

> I accept. But there was something in me that was angry. He didn't ask for my permission. Right? And then, you know, to pray to God, you know, it may be his concern or whatever, but he didn't ask my permission. (H 35:00–35:30)

Hope's analysis of this incident moves beyond personal offense to systemic critique. She identifies proselytizing as a habit "instilled" in Christian laity through patterns of practice that assume religious dominance. She names this as "power-over"—the exercise of religious authority without consent—and contrasts it with alternative models: "power-in-between" or "power-under" (H 36:00–37:00).

This incident becomes a lens through which Hope examines the broader dynamics of chaplaincy as a field shaped by Christian assumptions. She notes that despite explicit prohibitions on proselytizing in hospital settings, such behavior continues, often unchallenged because "they were not challenged" (H 40:00–40:30).

The Double Marginalization of Buddhist Chaplains

Hope identifies two directions from which Buddhist chaplains face misunderstanding or devaluation. The first is from the dominant culture, which may

dismiss or exoticize them. The second, perhaps more painful, is from within their own tradition:

> Unfortunately, because of our cultural values, you know, as monastics, one Buddhist layperson looks down at me because I'm doing social work instead of doing internal exploration… He's saying that I'm not practicing my Buddhist monastic tradition, you know, and he's teaching me that, you know, I should be more monastic by being in the temple and practicing meditation instead of being out and doing my service, you know, in society. (H 38:00–39:00)

This internal critique—that engaged service is somehow less authentic than traditional monastic practice—adds a layer of marginalization that Hope names as a "cultural misconception" requiring active correction. The Buddhist chaplain must defend their vocation both to the dominant culture and to their own community.

The Call for Collective Action

Hope's vision for the future of Buddhist chaplaincy is explicitly political and collective. She calls for Buddhist chaplains to "band together, create a training program, and exert… be a force in itself to break down these paradigms" (H 34:08–34:30). The goal is not merely to create parallel structures but to transform existing ones:

> We are being together; we are going there; we change CPE programs and make them truly interfaith or change them to multifaith and spread out that message there. (H 42:00–42:30)

She acknowledges the current reality: "We are working under their system" (H 34:01–34:06). But she refuses to accept this as permanent. The path forward involves building "stronger resources, connections where we can tap into each other's strengths, and be with each other's resources" (H 39:00–39:30). She notes that there are already training programs and associations for Buddhist chaplains, but they are scattered, unaligned, and therefore less impactful than they could be.

The systemic nature of the challenge heightens the urgency of this collective project. Individual excellence, like Hope's own successful navigation of the Cedars-Sinai program, is not enough. What is needed is an organized presence that can "hold them accountable" when institutions claim to be interfaith while maintaining practices that privilege certain traditions (H 40:00–40:30).

The Vision of Sharing Resources

Hope's personal trajectory—from MDiv to MFT to CPE to doctoral work—is driven by a vision of service to the Buddhist community. She undertook therapy training "so that I can learn this field and techniques, and then bring it to the Buddhist community" (H 41:35–42:00). She hopes that others will not have to repeat her path because she and others like her will "provide all this information" and "develop our communication skills" collectively (H 42:00–42:30).

This vision of shared resources and mutual support reflects Buddhist values of generosity and interconnectedness applied to professional development. It also represents a strategic response to the reality of scarce resources and scattered practitioners. By pooling knowledge and experience, Buddhist chaplains can become "a contending force by ourselves" (H 42:00–42:30).

Summary

Hope's narrative offers a distinctive contribution to understanding the lived experience of Buddhist monastics in CPE. Unlike participants whose narratives focus primarily on personal transformation or clinical skill development, Hope integrates these dimensions with a sophisticated critique of the power structures within which chaplaincy training occurs. The table below summarizes the superordinate and subordinate themes

derived from Hope's case analysis, offering a clear and organized view of the thematic structure that underlies her narrative.

Table 5: Hope's Personal Experiential Themes

Superordinate Themes	Subordinate Themes
• The Multifaith Framework as Liberation	• Interfaith vs. Multifaith Distinction • The Robe as Authority
• The Integration of Therapeutic and Buddhist Frameworks	• Clinical Confidence from Prior Training • The Challenge of Translating Buddhist Concepts • The Case of the Positivity Patient
• Buddhist Concepts in Clinical Practice	• Thematic Application of Core Teachings • Translating Buddhist Language
• The Dual Experience of Visibility and Misperception	• The Surprise of Open-Minded Tradition • Misconceptions and Rejections • The Kung Fu Question
• The Critique of Power and Vision for Transformation	• The Proselytizing Encounter • The Double Marginalization of Buddhist Chaplains • The Call for Collective Action • The Vision of Sharing Resources

Her overall experience at Cedars-Sinai was positive. The multifaith model allowed her to practice authentically. She had clinical confidence from her previous training and was able to connect meaningfully with patients and cohort members. Even here, she experienced instances of Christian dominance, such as patients who assumed she would proselytize, family members who proselytized to her without her consent, and a supervisor's comments that her Buddhist realism might undermine the faith of a Christian patient.

Such experiences, as well as the internal critique from within her tradition, make Hope the person who has successfully navigated the existing structures and who also envisions their transformation. Her call for Buddhist chaplains to "band together," to

create aligned training programs, and to "call out" institutions that claim interfaith values while maintaining Christian-centric practices represents a prophetic edge in her narrative.

The skills Hope brings—therapeutic training, clinical experience, Buddhist formation, and critical awareness—prepare her for this dual role of practitioner and reformer. Her vision of sharing resources so that others need not repeat her entire educational trajectory reflects both generosity and strategic thinking. In her story, individual success becomes the foundation for collective action, and clinical competence becomes the platform for systemic critique.

Hope's voice reminds us that Buddhist participation in CPE is not merely about individual formation but about the transformation of chaplaincy itself. As Buddhist chaplains become more numerous and more organized, they have the opportunity to reshape a field historically shaped by Christian assumptions into something more genuinely multifaith, where all traditions can practice with integrity, and where no patient or family member assumes that spiritual care means religious guidance, or that a robe means a missionary.

Case 4: Faye – The Phantom City

Participant Background and Context

Faye is a Buddhist nun from China, ordained in the Linji Chan (Rinzai Zen) lineage. She became a monastic in 2012, approximately eight years prior to her interview, and had spent the preceding four to five years studying in university settings (F 0:25–2:03). Her path to CPE was shaped by both academic requirements and a compelling vision of what chaplaincy might offer.

Two primary motivations led her to CPE. The first was pragmatic: her academic advisor recommended CPE as field education to fulfill degree requirements, describing it as "a systematic educational program on its own" that would complement classroom learning with experiential learning—a concept she names as *ziliang* (資糧), or self-training through practice (F 2:09–3:30).[190] The second was aspirational and deeply personal. A friend shared her experience of CPE, describing moments when she experienced "a sense of wholeness with her and the patient, basically, with another human being." This description resonated with Faye's Buddhist aspirations:

> That sounded very tempting to me because it, wow, is like, you know, a bodhisattva experience; you are complete with another being… I heard and learned from maybe the textual study, saying, "Oh, these kinds of experiences in the practice, in Buddhist practice. That's one of the very high, like high-level experiences you can get, because you eliminate yourself from your boundary, your division from the other, and the outside world. (F 3:30–5:00)

Faye completed her summer CPE unit at Brigham and Women's Hospital in Boston, a major teaching hospital affiliated with a cancer research center and trauma center. Her cohort was unusually large—twelve students across two concurrent groups—with members from diverse Christian, Catholic, and Jewish backgrounds and one lay Buddhist (F 5:37–8:30). The patient population included many cancer patients and trauma victims, representing what she describes as "the hardest situations that people can find… anyone can find themselves in" (F 8:30–9:30).

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[190] In Buddhist contexts, *ziliang* (資糧) literally means "provisions" or "supplies" for a journey. Spiritually, it refers to the accumulated merit and wisdom that a practitioner needs to progress along the path to enlightenment. Just as a traveler needs food, water, and money to complete a long journey, a Buddhist practitioner requires two kinds of "provisions": Merit provisions—accumulated through virtuous actions (e.g., generosity, ethical conduct, meditation); Wisdom provisions—developed through study, reflection, and direct insight into the nature of reality. Together, these provisions support the cultivation of the perfections (*pāramitās*) and enable one to attain liberation or Buddhahood. The concept is essential in both Theravāda and Mahāyāna traditions.

What distinguishes Faye's narrative is her profound honesty about struggle, failure, and the slow emergence of meaning. Unlike participants who emphasize their successes, Faye foregrounds her sense of inadequacy, her feeling of being an outsider, and her initial inability to connect Buddhist teachings with clinical practice. Her story is a particularly rich account of transformative learning, a path from confusion to insight, from perceived failure to compassionate understanding.

The Experience of Being an Outsider

The Multiple Dimensions of Otherness

Faye's experience of CPE was fundamentally shaped by her position as an outsider on multiple dimensions. She names these dimensions explicitly: as a foreigner from China in the United States, as a non-native English speaker, as someone with limited knowledge of Christian theology in what she calls "a Christian country basically," and as a visibly different Asian woman whom patients might perceive as "exotic" (F 19:46–21:00). Each dimension compounded the others, creating a profound sense of alienation.

This otherness was not merely subjective but was reflected in patient responses. She notes that patients likely felt "more curiosity than comfort" when encountering her—a response that, while not hostile, positioned her as an object of interest rather than a source of spiritual care (F 20:30–21:00). The exoticization of the Asian Buddhist monastic—the implicit "kung fu" question that Hope also mentioned—creates a distance that must be navigated before any genuine encounter can occur.

The Theological Outsider

Perhaps most significant for her CPE experience was Faye's theological otherness. In a cohort where most participants operated within theistic frameworks, she found herself unable to use their language authentically:

> When it was my turn, I said, "Oh, I feel like an outsider." Because, you know, basically I'm an atheist, and no gods or spirits, you know, work the way they would work. So, I don't feel, you know, I belong or blend in, in the space with… you know, other chaplains, with others who have the notion of God or a higher power. (F 17:30–18:30)

This theological alienation was not merely conceptual but affected her ability to participate in the core practices of CPE, including spiritual reflection and verbatim analysis. The language of God, grace, and divine presence—so natural to her peers—felt foreign and inaccessible. She was, in her own words, "an atheist" in a room full of theists, lacking the shared vocabulary that facilitated peer connection and learning.

The moment of relief came when a Jewish peer, an American in his second CPE program, shared that he, too, often felt like an outsider. This disclosure—"I thought I should be saying this"—revealed that outsider status was not uniquely hers and created a moment of genuine connection (F 18:30–19:00, 41:00–42:00). The compassion extended by her peers, who validated rather than dismissed her feelings, became itself a learning experience about the power of presence across difference.

Finding Connection Through Shared Language

Despite her general sense of otherness, Faye discovered one domain where the outsider position reversed: with Mandarin-speaking patients. When colleagues referred Chinese patients to her, she found that "the tradition, you know, the religion transcends…

nationalities transcend the religion" (F 22:00–22:30). Shared language and cultural background created an immediate connection that transcended religious difference.

The case of a young man from China receiving leukemia treatment illustrates this dynamic. With no one else to support him and his parents, who were "24 hours, seven days with him," Faye's visits became essential. The mother would talk for an hour or more, finding in Faye someone who could understand not only her words but also her cultural context of suffering (F 22:30–23:30). In these encounters, Faye's otherness became presence, her foreignness became familiarity, and her Buddhist identity became secondary to shared humanity.

The Experience of Failure and Its Gifts

The Painful Visit

Faye's narrative is remarkable for its candid admission of perceived failure. The case that haunts her involves a woman in severe pain from cancer, for whom morphine provided insufficient relief. The nurse had called for a chaplain, and Faye responded:

> I walked in; her husband was there. She was there. And I had no idea what to do… She didn't want to talk. Because, you know, she didn't have the energy. So, I stood there, and I mainly talked to the husband, saying, "Oh, if you want to pray, there is a chapel downstairs; you can go and pray. And you can also go to the service at noon." And I stood there. And I felt as if… I felt myself useless. (F 13:30–14:30)

The image of Faye standing helplessly, offering suggestions about the chapel rather than direct spiritual care, captures her sense of inadequacy. She intuited that meditation might help—"I had the idea to say, 'Oh, maybe we could do meditation'"—but lacked the specific technique for addressing acute pain (F 14:30–15:00). The visit

ended with her leaving, feeling that she had offered not comfort but "broad embarrassment."

This experience could have remained merely a story of failure. Instead, it became generative. Immediately after leaving, Faye sought out the hospital's Buddhist chaplain to ask, "What would you have done?" This query led to learning about meditation for pain management—a skill she would later develop and use (F 15:00–15:30). The failure, honestly confronted, became motivation for learning.

Self-Assessment and Growth

Faye's overall self-assessment is characteristically modest: "I wouldn't say that I performed well during the CPE" (F 11:38–12:00). She attributes this partly to personality—"I'm not the kind of person who knows who has, you know, the high EQ and who knows how to comfort people"—and partly to the inherent difficulty of the work: "It's what you fear the most, and you go and embrace that" (F 12:00–12:30).

Yet her narrative reveals significant learning. She identifies two key takeaways: first, "the importance of processing in groups for community building and the support that group, you know, the community group offers" (F 16:30–17:00); second, the discovery that patients need "so little to get comfort" when offered guided meditation or simply presence (F 17:00–17:30). Through struggle, she learned these lessons, which became integral to her understanding of spiritual care.

The Ongoing Process of Reflection

Faye emphasizes that her learning from CPE continues beyond the program, through continuing reflection. Months later, insights continue to emerge: "I have been processing the experience, even up to now. Upon reflection, I think I would perform

better knowing more clearly who I am" (F 12:00–12:30). The painful visit to the woman in pain came back to her last week during the interview, still alive as a source of learning (F 15:30–16:00).

This continuing reflection suggests that for Faye, CPE was not merely a training program but an initiation into a way of being that includes ongoing self-examination and growth. What could have been a simple source of shame transformed into a valuable teacher through sustained reflection.

The Struggle to Integrate Buddhist Teachings

The Puzzle of Application

When asked about applying Buddhist concepts in clinical practice, Faye responds with striking honesty: "Actually, I think this question is interesting. This is what puzzles me a lot. In particular, during the CPE program, so I struggled very, very hard" (F 30:02–30:30). The requirement to provide theological or Dharma reflection on clinical encounters felt like an impossible task:

> It was like, oh, you know, you got this big thing, this very difficult task, and I wasn't prepared. And then it was thrown at me, you know, and I was shocked and very frustrated. (F 31:00–31:30)

This struggle reflects what Faye identifies as a fundamental challenge for Buddhist chaplaincy: the tradition has not been interpreted in a way that applies to clinical contexts. "We need the interpretation, or this situation, I think, is probably what makes sense to you to do this study, which is meaningful" (F 30:30–31:00). The gap between textual knowledge and clinical application is not a personal failing but a collective challenge requiring new forms of interpretation.

The Phantom City Revelation

The breakthrough in Faye's understanding came not during CPE but afterward, through a reading group focused on the Lotus Sutra. As participants read the parable of the Phantom City—a story in which a guide creates an illusory city to encourage weary travelers on a dangerous journey—a classmate connected it to her experience of needing a "resting place" before a difficult life transition (F 32:30–34:00).

This connection illuminated Faye's own clinical experience:

> That hit me as, Oh, so what I have been doing, what I was doing with that visit with a man, I was creating a phantom city for him to regain his courage, his strength, and, you know, processing… Something was happening within him when I was there, when I was creating the space for him to talk, for him to be vulnerable. (F 34:30–35:30)

The man in question, recently diagnosed with pancreatic cancer, had told Faye that she was the first person he could talk to about his diagnosis—his family was too scared to hear it. His tears and gratitude revealed the value of her presence, but she had lacked a framework to understand what had occurred. The Phantom City parable provided that framework, revealing that her role was not to fix or teach but to create a temporary refuge where strength could be regained.

Faye notes the significance of this interpretation: "It's not all about, you know, emptiness. It's not all about, you know, the traditional way of interpreting how… Oh, you got your karma. This is your retribution. You've got to take it. So, it's more humane" (F 35:30–36:00). The lens of compassion, rather than the lens of philosophical abstraction, made the teaching clinically relevant.

The Inapplicability of "Big Words"

Faye is direct about the limitations of traditional Buddhist vocabulary in clinical settings. Terms like "suffering," "emptiness," and "impermanence" are, in her assessment, "too big, too hollow"—too abstract and potentially alienating for patients in crisis (F 39:06–39:30). She questions whether anyone in acute suffering wants to hear such teachings:

> I don't think that, at the hospital, teaching about the brutal truth is very far from random chaplaincy. Not likely… It's really, really hard, but this is what I was equipped with. I wasn't prepared for these possible visits. (F 39:30–40:00)

The fundamental reality that chaplains face, Faye suggests, is not philosophical but existential: people are in pain, afraid, and struggling to cope. In such moments, "they don't need this teaching" about emptiness or karma (F 41:00–41:30). What they need is compassion—a quality she found more reliably in her peers' responses to her outsider status than in abstract Buddhist formulations.

This insight leads Faye to a broader critique of her tradition's emphasis: "We tend to talk about the lofty concept of emptiness, you know, but really, maybe it's me, but I don't see that we're so enthusiastic about how to cultivate compassion" (F 31:30–32:30). The imbalance between wisdom (*prajñā*) and compassion (*karuṇā*) in traditional Buddhist education, she suggests, leaves monastics ill-equipped for the relational work of chaplaincy.

The Negotiation of Multiple Identities

Being Buddhist Selectively

Faye describes a flexible approach to her Buddhist identity in clinical practice. She is explicitly Buddhist only in certain contexts:

> I think I'm a Buddhist only when I visit Chinese or Buddhist patients. Or when people are accepting, they're curious and then are open to it… Otherwise, I am just an interfaith chaplain, or I'm a humanist, or an atheist. Yeah, whatever I needed to be. (F 27:32–28:30)

This flexibility is not, for Faye, a betrayal of her tradition but a practical response to patients' needs. When praying with Christian patients, she uses their language—"God or Father"—and integrates visualization techniques that align with their imagery while drawing on her meditation training (F 26:00–27:00). The goal is not to maintain Buddhist purity but to "meet their needs, meet where they are at" (F 27:00–27:18).

Boundaries and Precepts

When asked about contradictions between her role as a Buddhist monastic and as a spiritual caregiver, Faye offers a pragmatic framework:

> I think about it, really. I mean, the contradictions or obstacles with my role as a Buddhist monastic. It's my personal, I think, as long as it doesn't contradict, you know, the first major precept, and it doesn't break the major precept; it doesn't matter. Because I'm there to, you know, do my job, other than learning, but I'm learning in doing my job, which is to provide comfort for people. (F 28:30–29:30)

This principle—that anything not violating the major precepts is permissible in service of providing comfort—establishes a clear boundary while allowing enormous flexibility. The monastic identity sets ethical limits but does not prescribe particular forms of expression. Faye can pray in Christian language, use visualization with theistic imagery, and adapt her presentation to each patient because none of these actions violates core precepts.

The Institutional Support

Faye notes that the hospital's structuring of spiritual care services supported her ability to navigate multiple identities. At orientation, chaplains were "empowered" to present themselves as interfaith chaplains regardless of their personal tradition (F 24:30–

25:00). A pamphlet containing prayers from various traditions enabled her to learn and recite Catholic prayers, such as the Our Father, which she could memorize through repetition (F 25:30–26:00). These institutional resources provided a bridge between her Buddhist identity and the needs of predominantly Christian patients.

The Vision for a Compassion-Centered Buddhism

Rebalancing Wisdom and Compassion

Faye's critique of traditional Buddhist education—its overemphasis on wisdom and underemphasis on compassion—leads to a constructive vision for Buddhist chaplaincy training. She argues that compassion must be foregrounded:

> In order to, you know, make it useful and welcomed… we should dig into the compassion part of the teaching. And even for the same text, we read it instead of, you know, oh, this teaches about, you know, this, and we read it through the lens of compassion and care. (F 32:30–33:30)

This "lens of compassion" transforms how Buddhist texts are interpreted and taught. The Phantom City parable, traditionally read as a critique of Hinayana as merely a halfway station, becomes a story about the Buddha's compassionate response to human limitation. The Buddha's initial reluctance to teach after enlightenment becomes evidence not of his wisdom but of his compassion in overcoming that reluctance (F 36:30–37:30). Reading through the lens of compassion reveals dimensions of the tradition that wisdom-focused readings obscure.

Existing Resources and Models

Faye notes that resources for compassionate care already exist within Buddhism, though they may need adaptation. She describes a Tibetan Buddhist colleague who trained in a program "based on the teaching on the Bodhisattva's Way of Life" but

"stripped off any color of Buddhism or any reference to Buddhism" for clinical application (F 29:00–30:00). Mindfulness-based programs also offer models for bringing Buddhist-derived practices into clinical settings.

She suggests that Tibetan Buddhism may have particularly rich resources for compassion training, though she hesitates to make a firm claim about Chinese Buddhism: "I'm not sure. I need to, no more to claim to make this claim" (F 42:30–43:00). Her approach is characterized by humility about her own tradition's resources and openness to learning from other Buddhist traditions.

The Wooden Bucket: A Parable of Adaptation

In a concluding reflection added after the formal interview, Faye offers a powerful metaphor for why Buddhism must engage with settings like hospitals.[191] She describes a piece of wood left in the forest, unused, that eventually rots. But if that same wood is made into a bucket or a shovel—something useful—then "when people want to hold water, or to clean, or to shovel dirt, they will actively seek and find that wood and use it; they will preserve it" (F added section).

The application to Buddhism is explicit:

> The same with Buddhism: if we are marginalized, we want to keep our way fine, but then you'd better think about your future. If you want to keep your way that goes along with the trend, then it contradicts what the Buddha taught, because the Buddha taught according to how people would take it, and also the Buddha was going with the trend. If we keep the trend and take it as it is, we are losing the teaching. (F added section)

[191] Once the formal interview wrapped up, I turned off the recorder and we transitioned into a casual conversation in Chinese. However, the discussion quickly took an interesting turn, touching on some thought-provoking subjects. Intrigued, I switched the recorder back on and asked her to share her insights on those points in English. This yielded an additional five-minute segment of valuable commentary.

This metaphor captures Faye's understanding of the relationship between tradition and adaptation. Adaptation is survival, not betrayal; the condition of relevance, not dilution. The Buddha himself taught according to his audience's capacity—"going with the trend" in the sense of meeting people where they were. To refuse adaptation is not to preserve the teaching but to lose it, as the unused wood is lost to rot.

The hospital, in this framework, is not a place where Buddhism is compromised but a place where it can become useful—and therefore preserved. The same compassion that drove the Buddha to teach also drives chaplains to visit patients, even knowing they may face rejection. The willingness to change how Buddhism is practiced is not a departure from tradition but a return to its source.

Summary

Faye's narrative traces a trajectory from confusion and perceived failure to dawning insight and compassionate understanding. Her CPE experience was marked by profound feelings of otherness—as a foreigner, as a non-native English speaker, as a non-theist in a theist-dominated field, and as an exoticized Asian woman. These multiple dimensions of outsider status could have paralyzed her; instead, with the support of peers who validated her experience, they became a ground for learning. The table below summarizes Faye's personal experiential themes as derived from the case analysis, providing a clear, organized picture of the thematic structure underlying her narrative.

Table 6: Faye's Personal Experiential Themes

Superordinate Themes	**Subordinate Themes**
• The Experience of Being an Outsider	• The Multiple Dimensions of Otherness • The Theological Outsider • Finding Connection Through Shared Language

Superordinate Themes	Subordinate Themes
• The Experience of Failure and Its Gifts	• The Painful Visit • Self-Assessment and Growth • The Ongoing Process of Reflection
• The Struggle to Integrate Buddhist Teachings	• The Puzzle of Application • The Phantom City Revelation • The Inapplicability of "Big Words"
• The Negotiation of Multiple Identities	• Being Buddhist Selectively • Boundaries and Precepts • The Institutional Support
• The Vision for a Compassion-Centered Buddhism	• Rebalancing Wisdom and Compassion • Existing Resources and Models • The Wooden Bucket: A Parable of Adaptation

The clinical encounters that most challenged Faye—particularly the visit to the woman in unrelieved pain—became sources of motivation for further learning. Her honest self-assessment, "I wouldn't say that I performed well," reflects an accurate perception of her own limitations at the time, not self-deprecation. Yet these limitations, honestly confronted, led her to seek the Buddhist chaplain, to learn meditation for pain, and to develop skills she would later use.

It was difficult to integrate Buddhist teachings into clinical practice. Faye had difficulty with the need to provide Dharma reflection and felt unprepared and frustrated. Later, the breakthrough came through a reading of the Lotus Sutra that revealed the Phantom City parable as a template for understanding her role as one who creates temporary refuge for those in distress. This reading through the lens of compassion rather than doctrinal correctness became a model for how Buddhist texts might be reclaimed for clinical contexts.

Faye's critique of her tradition's overemphasis on wisdom and its neglect of compassion is both personal and systemic. She recognizes in herself a tendency to value

abstract understanding over practical care—a preference reinforced by traditional education. Her calling is to restore balance between wisdom and compassion, to read texts through the lens of care, and to develop training programs that place compassion at the center. This vision for Buddhist chaplaincy is both faithful to tradition and responsive to clinical realities.

This vision is poetically captured in the metaphor of the wooden bucket. Buddhism that remains unused—confined to monasteries and texts, unwilling to engage the world of suffering—will rot. But Buddhism that makes itself useful, that becomes a vessel for holding tears or a tool for clearing away despair, will be sought and preserved. The hospital is not a threat to Buddhist identity but an opportunity for Buddhist relevance. And the chaplain, however reluctant, however aware of her own limitations, becomes in her very presence a phantom city, a place of temporary refuge where strength can be regained for the journey ahead.

Case 5: Lynn – Quest for Balance

Participant Background and Context

Lynn is a Buddhist nun with an extraordinary breadth of training across multiple Buddhist traditions. Ordained in the Linji Chan tradition in 1993, she subsequently received training in Tibetan Buddhism for one year, spent three years in Thailand in monastic training, and studied Mahāyāna Buddhism for several years (L 0:00–1:00). This multi-tradition foundation—rare among monastics—gave her a unique perspective on Buddhist practice before she ever encountered CPE.

She came to the United States in 2000 and pursued academic study in psychology and religion while continuing to teach meditation and Buddhism. Her CPE journey began in 2015 at Cedars-Sinai Medical Center, followed by a residency at Stanford Hospital, completed in 2016. She then completed a one-year specialty fellowship in palliative care (2016–2017) and obtained board certification in 2017. Since then, she has worked as a palliative care chaplain at Stanford, serving in both the emergency department and the cancer center, while also assisting in CPE student training (L 1:00–1:49, 13:00–13:14).

Lynn's motivation for pursuing CPE was distinctive and revealing. After graduating in 2014, she received offers to teach in Buddhist schools in Thailand and mainland China but found herself questioning whether she wanted to spend more time in academic settings. More fundamentally, she was troubled by a pattern she observed:

> If I see the struggles of all the monastics, I have several, I think, very good dharma friends; they disrobed, both monks and nuns, in Taiwan, in Thailand, or in mainland China… This makes me think why they're ordained for 20 or 30 years, and they started to disrobe. And finally, I found out, of course, for many reasons; one reason I found is that I don't think we're really practical Buddhism. (L 1:54–3:00)

This critique of "practical Buddhism" led her to a personal challenge: "Every day I teach suffering; I teach the students the Four Noble Truths. Then all these teachings, how do I really… Do I really understand the sufferings? So, I want to test myself; also, I want to give myself a chance to learn and to make more progress for myself" (L 3:00–3:30). CPE thus became a field test for her Buddhist learning—an opportunity to move from theoretical understanding to embodied practice.

The Quest for Balance Between Monastic and Chaplain Identities

The Fundamental Puzzle

Lynn's narrative is organized around a central tension that she names explicitly: the need to find balance between being a good monastic and being a good chaplain. This is not a tension she resolved quickly, but one she continues to navigate:

> I always find the middle path. I have to be a good monastic first, and I want to be a good chaplain at the same time. I always find my balance. If I really am a wonderful chaplain, sometimes I will lose my monastic identity; it is easy to lose it. But if I am only a good monastic, I may not be a good chaplain. I always found that balance, that fundamental puzzle. (L 14:00–14:45)

This "fundamental puzzle" manifests in countless daily decisions. Should she stay after hours with a crying patient who requests her presence? The monastic training says yes—monastics are available 24/7, 365 days a year. The CPE training says no—professional boundaries require leaving at the designated time (L 15:30–16:30). Should she pray publicly for a hospitalized temple member? Monastic practice would include the community in such prayer; chaplaincy ethics require protecting patient privacy (L 17:00–18:00).

Lynn's framing of this tension as a "middle path" is significant—she uses Buddhist language to describe the resolution of a conflict between Buddhist and professional norms. The middle path is not a compromise but a higher integration that honors both.

The Struggle with Professional Boundaries

The most concrete manifestation of this identity negotiation is Lynn's struggle with professional boundaries. She identifies this as her "biggest weakness" in CPE

training: “I do not know how to set a boundary with the patients and my staff” (L 9:50–10:10).

Her examples reveal the depth of the conflict. With homeless patients who needed reading glasses, she found it natural to buy them—“just one or three dollars”—but learned this violates professional boundaries (L 10:10–10:30). With Asian patients who developed friendly relationships, she struggled when they asked for personal phone numbers, email addresses, temple addresses, and WeChat contacts. “As a Buddhist monastic, it is very normal, right? But as a chaplain, we do not allow you to become this because you do not have a professional relationship with clients” (L 10:30–11:20).

The boundary issue extended to colleagues as well. Lynn’s natural inclination was to bring gifts, cook vegetarian food for students, or offer money to those short on funds—behaviors completely normal in monastic-lay relationships but problematic in professional settings (L 11:20–12:10). She summarizes the ongoing challenge: “It’s not easy for me. I’m still learning. I’m still practicing; I always tell myself: no gift to anybody. And no donation for them” (L 12:10–12:30).

The Conflict of Cross-Unit Coverage

A pivotal learning moment came during her residency when she faced a conflict over a dying Buddhist patient who had been transferred to another unit. The patient’s family, desperate for Buddhist support, called her repeatedly. The unit chaplain was busy, and language barriers complicated communication. Lynn went to the patient, provided a Buddhist service, and the patient died peacefully. The family wrote an appreciation card, and the credit went to Lynn—leaving the unit chaplain “a little bit unhappy” (L 19:30–21:00).

Looking back, Lynn recognizes this as her error:

> I realized later that it is my fault. I should not follow up. I should not, because our policy is that I only cover my patients in my unit, right? As long as the patient transfer is not my patient. Every unit has a unit chaplain; those are the chaplain's patients. Only I can go to visit this patient when the unit chaplain makes a referral for me. (L 20:30–21:10)

Her reflection reveals the shift from monastic to professional reasoning. At the time, she acted from a nun's duty: "The patient is dying. Because the patient is Buddhist and the family is not, the family is really confused and struggling. They want Mom to die peacefully by following her beliefs… Only the nun can support" (L 21:00–21:30). Now she understands that professional chaplaincy requires respecting institutional structures, even when they seem to conflict with immediate compassionate response.

This learning has transformed her practice: "Now, I'm really very clear about that boundary. Boundary, very clear… Patients want to attach with chaplains, yeah, right? Yeah, that's what I've learned also; that's my big change" (L 22:30–23:00).

The Transformation of Emotional Awareness

The Discovery of Tears

One of the most striking elements of Lynn's narrative is her account of emotional transformation through CPE. Before training, she had gone "almost 10 more years" without crying: "Never have… no tears in almost at least 10 more years" (L 19:00–19:30). Her CPE supervisors challenged this:

> They try to guide me to have tears and help me to think about the scenes that are miserable, scenes making you feel sad and disappointed, and then I tell them what happened. Right? Then the supervisor said, "Where are your tears?" I said, "Why should I have tears?" They think we should have tears; the reason is, if you do not feel the pain, how can you feel the patient's pain? (L 19:30–20:00)

Lynn's initial response reflected her monastic training: she had "processed all that grief already" through Buddhist practice, viewing events through the lenses of impermanence and karma. When she thought of painful memories, she felt no suffering, no grief, no tears (L 20:00–20:30).

But the supervisors' challenge prompted a shift: "I asked myself why, if other people experience these events, how do they feel about their loss or about their discontent in life? So, I tried to imagine others, and then later I found that it brought me back to the other stage. I think I still have tears" (L 20:30–21:00). Now she cries at movies, experiences sadness, and acknowledges emotions that were previously inaccessible.

The Problem of "No Feeling"

Lynn extends this reflection to question whether Buddhist equanimity might sometimes mask emotional disconnection. She recounts an incident with a monk from Australia who saw snow for the first time at age sixty:

> I asked him, "How do you feel?" He told me, "No feeling." I said, "You should feel excited! Because, you know, you are almost 60 years old, you have never seen snow in your life." He said, "No feeling"—that's an issue; we're still ongoing with this kind of issue. Is that right or wrong? I don't know. You can say, as a monastic, it's right. We do not… our emotions do not wave by following the environment, right? Do not shake over the waves by following the environment. That's good monastic training, I think. But as a clinical training, CPE training, I don't think that's the right answer; we should have feelings. (L 22:30–23:30)

The question Lynn poses is profound: If a monastic cannot feel excitement at a first snowfall, how can they understand a patient's feelings when facing similar novelty or loss? "If I have never seen the snow in the past 60 years, you first time see the snow also. I tell you—you see? They are like flowers, stars… and no feelings? Then in the CPE training, they may question you: Then how do you understand the patient's feelings, if a patient is experiencing the same things?" (L 23:30–24:00)

This questioning does not reject monastic training but seeks integration. Lynn's resolution is not to abandon equanimity but to add emotional awareness—to know one's feelings while not being controlled by them. She now experiences herself as "more sensitive and aware of my feelings; also, I can know how those feelings are right away" (L 33:30–34:00).

The Cultural Complexity of Monastic Emotion

Lynn notes that her emotional transformation creates tension within Buddhist communities. After three months of CPE, she told two Buddhist laypeople, "I think, you know, today I'm very sad." They were shocked: "Venerable, what's wrong with you?" They had never heard a monastic express sadness (L 21:30–22:00).

Even now, she navigates different expectations in different contexts: "Until now, I still can tell my laypeople I'm sad or I'm angry, I also can. I still cannot tell other monastics that I think I'm sad, I'm angry. Then they will tell me, 'Venerable, go to more meditation, do more chanting'" (L 22:00–22:30). This bifurcation—emotional honesty with laypeople, emotional containment with monastics—reflects the ongoing negotiation between her two worlds.

The Clinical Application of Buddhist Wisdom

The Rule of Not Teaching

Lynn articulates a fundamental principle that guides her clinical practice: in the hospital, she does not teach. This represents a radical departure from her monastic role:

> As a spiritual care counselor, I am not a teacher. We don't help patients, we don't fix patients, we don't change patients; we will only work alongside a patient to assist them to find their own coping skills… That's a big difference with the monastic; as a monastic, I always teach the laypeople, tell them what suffering is,

> tell them what the Buddha taught, and tell them: You have to follow the five precepts; you have to do this; you should not do that. (L 28:30–29:30)

The chaplain's role, in contrast, is to "let them find by themselves… They are in the bottom of the Valley, right? We do not pull them out of the Valley. No, we just walk maybe behind them. I mean, on the side of them and walk with them together; let them climb out by themselves" (L 29:30–30:00).

This distinction is not merely theoretical but shapes every interaction. Lynn must constantly shift between roles: "When I come back to temples, I still do my monastic job; I still teach them, tell them to be vegetarian, and tell them to meditate and to recite the Amitabha Sutra. But when I go to the hospital, I will be an interfaith chaplain; I do not offer any teachings, even though that is difficult for us" (L 30:00–30:30).

The "Why" Question and Buddhist Resources

Lynn identifies a critical difference between Buddhist and Christian frameworks in addressing suffering. When patients ask "why"—why my son is dying at twenty, why bad things happen to good people—CPE training teaches chaplains to respond, "I really don't have answers for you" (L 31:00–31:30).

But Lynn notes: "As a monastic, I can tell them why—why this happened. I can tell them, right? I can open the Buddhist scriptures" (L 31:30–32:00). Buddhism offers explanations through karma, causes and conditions, and the nature of existence. Yet clinical training prohibits offering such explanations unless patients explicitly request them.

This creates an ongoing tension she has discussed with supervisors: "I don't know the exact reasons because this is what Westerners, counselors use; they do not allow to provide tools, or because they have no tools to give" (L 32:00–32:30). Her observation

that Christian chaplains may have "no tools" beyond "God's will" highlights a distinctive Buddhist challenge: having rich explanatory frameworks that must be withheld in clinical contexts.

In practice, Lynn has learned to read patients' cultural backgrounds. "Most of the Asian patients want to get my suggestions. Westerners don't want to listen. They just want to explore their emotions" (L 32:30–33:00). She initially tried both approaches but now consistently uses professional skills: "I do not offer teachings" (L 33:00–33:30).

The Subtle Application of Buddhist Content

Though Lynn does not explicitly teach Buddhism, she constantly applies Buddhist principles in ways adapted to each patient. Compassion, unconditional love, bodhicitta, and meditation are the resources she draws upon, yet "I usually do not use Buddhist terms; I use the content" (L 34:30–35:00).

This distinction between terms and content is crucial. Lynn leads meditations, guides patients to release fear and worry, and helps them find peace before death—all while avoiding Buddhist vocabulary unless patients introduce it. The teachings are present, but they are offered as invitations rather than instructions, as possibilities rather than prescriptions.

She reflects on this as "a very interesting process. You know how to adopt all your learnings in your religion; maybe you think that path really benefits this patient, but how to bring that knowledge? I think it is a very interesting process. But always remember, we do not teach them. I think that's the key" (L 36:00–36:30).

Meditation as Clinical Tool

Meditation emerges in Lynn's narrative as a primary vehicle for applying Buddhist wisdom in clinical settings. Her approach is highly individualized, drawing on decades of personal practice (over thirty-two years) and extensive clinical experience (L 42:30–43:00).

She teaches meditation differently to each patient, adapting to "their medical situations, their personalities, and their living environments" (L 42:00–42:30). For patients with physical pain, she uses body scans but tailors them to specific locations and patient temperaments. A calm patient might receive a full body scan from head to toe; a patient with a "very hot temperament" receives a shorter scan focused on a specific area (L 44:00–45:00).

For patients on the deathbed who cannot feel their bodies or follow their breath, she improvises: "'Do you know where you are right now?' 'Yeah, I'm in the bed.' And so, you ask, 'Yeah, can you see the shape of your bed? The shape?' 'Yeah, I'm on the single bed.' 'How is your bed?' He said… Okay, now we practice meditation concentrating on this bed" (L 46:30–47:00). This adaptation—using whatever object of concentration is available—draws on Buddhist principles while meeting the patient exactly where they are.

Lynn emphasizes that effective clinical meditation teaching requires more than technical knowledge: "If you have never practiced meditation, that is totally different. Even though you are a native speaker, English is much better than mine. But my leading and your leading, the result is different" (L 41:30–42:00). The teacher's own practice matters; meditation cannot be reduced to words.

The Critique of Traditional Buddhist Practice

The Question of Practical Buddhism

Lynn's entire CPE journey began with a critique: "I don't think we're really practical Buddhism" (L 2:30–3:00). This critique deepened through her clinical experience. She contrasts the protected environment of temples and schools with the raw reality of hospitals:

> I found my personal practice has big, huge progress compared with my 20 more years before, practicing in the temples and schools; that's a big difference… You really see the sufferings; you work with all the people from diverse religious backgrounds. (L 38:00–39:00)

Clinical work has become for her a form of practice that complements and deepens traditional monastic training. The wisdom gained from being with dying patients, from navigating diverse perspectives, from managing her own reactions—this wisdom could not be gained in a temple.

The Tension with Senior Monastics

Lynn's path has not been universally supported within Buddhist communities. She acknowledges "disagreement between me and my professors and my other senior masters" (L 55:30–56:00). Their critique is significant: by working with non-Buddhists and those who will not attain liberation in this lifetime, she is not fulfilling the highest Buddhist goal of freeing beings from suffering and rebirth.

Lynn's response reveals her developed perspective:

> They told me you are a nun; also, you've spent almost seven years… Why don't you teach Buddhism? They just set up standards here. My standard is, maybe a little lower. Compared with them, their expectations… I just hope people leave well and die well. (L 56:00–57:00)

She acknowledges that patients may still have cravings and may be reborn but argues that her work plants "good seeds" in their consciousness. Even if they do not achieve liberation, they may have a better rebirth, a better life, and more spiritual capacity in the future (L 53:30–54:30).

This defense is not merely pragmatic but draws on Buddhist psychology: the seeds planted through meditation and compassion remain in the storehouse consciousness (*alaya*) and bear fruit in future lives. Her work, though not achieving ultimate liberation for patients, contributes to their long-term spiritual trajectory.

The Wooden Bucket Revisited

Like Faye, Lynn implicitly addresses the question of Buddhism's relevance through a metaphor of usefulness. She notes that some senior monastics question why she doesn't simply teach Buddhism in temples or schools. She responds that certain groups of people—those in hospitals, those facing death—would lose their chance to receive any spiritual support if she and others like her were not present (L 54:30–55:00).

This echoes Faye's metaphor of the wooden bucket: Buddhism that makes itself useful will be preserved; Buddhism that remains only in traditional settings may become irrelevant. Lynn's clinical service is not a departure from the Buddhist mission but its enactment in new contexts.

The Distinctive Contributions of Buddhist Chaplains

The Energy of Compassion

Lynn identifies compassion as the primary gift Buddhist monastics bring to clinical settings. This is not merely a theoretical commitment but something patients perceive directly:

> Patients are very sensitive… Many patients are dying; they are also very sensitive, and many psych patients are also very sensitive. When you do the initial visit, usually they can feel that if you have compassion, they can feel that. They call it "positive energy." (L 30:00–31:00)

She recounts a patient who requested follow-up visits specifically because she saw Lynn's "positive energies" even through a video screen. Lynn reflects, "I think that energy from my Buddhist training, from my compassionate heart" (L 31:00–32:00).

This sensitivity to energetic presence suggests that what Buddhist chaplains offer transcends techniques and words. The years of meditation and ethical training shape a quality of being that patients perceive and respond to, even across cultural and linguistic barriers.

Meditation Resources for Clinical Settings

Lynn has actively brought Buddhist meditation resources into the hospital but adapted them to the institutional context. She leads weekly meditation for staff; has established "comfort corners" or "sacred spaces" (which are essentially meditation rooms, though named differently); and conducts research on meditation interventions (L 29:00–30:00, 48:00–49:00).

She is involved in a study of one hundred ICU patients, teaching meditation one-to-one and tracking outcomes. This research orientation, rare among chaplains, reflects her commitment to demonstrating the value of contemplative practices in measurable ways (L 42:00–43:00).

Serving Beyond Buddhism

Lynn emphasizes that her role as an interfaith chaplain means serving everyone, not only Buddhists. She has learned to pray in Christian language, to lead meditation for

patients of all traditions, and to provide emotional and spiritual support regardless of religious background.

This universal service is grounded in Buddhist vows: "In Buddhism, we can benefit all the people in the world, right? Because we make vows, we will serve all sentient beings, even animals. So why can't we serve non-Buddhists? That doesn't make sense, right?" (L 39:30–40:00). The bodhisattva vow to serve all beings logically extends to non-Buddhists in clinical settings.

Wisdom for Buddhist Chaplaincy Training

Essential Knowledge Areas

Drawing on her extensive experience, Lynn offers concrete recommendations for Buddhist chaplaincy training. First, she emphasizes cross-cultural psychology:

> I really suggest all these Buddhists. If you want to be a better interfaith chaplain, you should learn cross-cultural psychology… American thoughts and Asian thoughts, Western and Eastern, really have huge differences. (L 37:30–38:00)

She illustrates this through clinical experience: Asian patients often want suggestions and will follow them; Western patients want to express emotions and do not want advice. Understanding these differences prevents cultural missteps and enables effective care.

Second, she recommends basic knowledge of other religions. Her study of comparative religion and friendships with Catholic nuns have equipped her to work across traditions (L 39:30–40:00).

Third, she emphasizes genuine meditation practice: "Please practice daily. That's very important" (L 41:30–42:00). Without personal practice, leading meditation becomes mere recitation; with practice, one can adapt teachings to each patient's unique situation.

Realistic Expectations for Monastics

Lynn offers practical advice for monastics entering CPE. First, adjust expectations about respect: "Don't expect people to respect us as monastics. I have always believed that respect is not a gift; you have to earn it" (L 52:30–53:00). In hospital settings, colleagues use first names, not titles; the hierarchical respect of temple life does not apply.

Second, be aware of how monastic habits may be perceived. She notes that some monastics begin their day by sitting quietly with tea, meditating before work. While this is good practice, peers who do not understand meditation may perceive it as simply drinking tea on the job. Awareness of these perceptions matters, especially for new students (L 53:30–54:30).

Third, recognize that what brings joy to monastics may differ from what brings joy to others. When colleagues ask about self-care and suggest activities like shopping or socializing, monastics may find genuine joy in study, meditation, and teaching. This difference should be understood rather than judged (L 55:00–56:00).

The Balance Article

Lynn references an article that profoundly influenced her understanding of Buddhist chaplaincy—written by a senior American Buddhist teacher over a decade ago. The article's key insight is that becoming a chaplain is not a departure from Buddhist practice but an opportunity to practice bodhisattva vows and bodhicitta in a new context (L 49:30–50:30).

This reframing addresses the anxiety many monastics feel about losing their identity. Lynn notes, "The reason why many monastics drop this training is that they did not find that balance. They worried they could not become a good monastic if they

accepted all this training" (L 50:30–51:00). The article helped her see that the clinical setting is not a threat to monastic identity but a field for its expression.

She encourages questioning and discussion: "You have to read, you have to practice, you have to ask questions, discuss with your supervisors, and question them; then you have deeper, deeper, deeper understanding" (L 51:00–51:30). Through this process, monastics can find the balance that allows both "happy monastic life and happy clinical interfaith chaplain life" (L 51:30–52:00).

Summary

Lynn's narrative traces a remarkable journey from traditional monastic training through CPE to an integrated identity as a Buddhist nun and palliative care chaplain. A critique of "practical Buddhism" motivated her path—the belief that theoretical knowledge of suffering required real engagement with suffering. Derived from case analysis, the table below summarizes Lynn's personal experiential themes and provides a well-structured overview of the thematic framework within her narrative.

Table 7: Lynn's Personal Experiential Themes

Superordinate Themes	**Subordinate Themes**
• The Quest for Balance Between Monastic and Chaplain	• The Fundamental Puzzle • The Struggle with Professional Boundaries • The Conflict of Cross-Unit Coverage
• The Transformation of Emotional Awareness	• The Discovery of Tears • The Problem of "No Feeling" • The Cultural Complexity of Monastic Emotion
• The Clinical Application of Buddhist Wisdom	• The Rule of Not Teaching • The "Why" Question and Buddhist Resources • The Subtle Application of Buddhist Content • Meditation as Clinical Tool
• The Critique of Traditional Buddhist Practice	• The Question of Practical Buddhism • The Tension with Senior Monastics • The Wooden Bucket Revisited

Superordinate Themes	Subordinate Themes
• The Distinctive Contributions of Buddhist Chaplains	• The Energy of Compassion • Meditation Resources for Clinical Settings • Serving Beyond Buddhism
• Wisdom for Buddhist Chaplaincy Training	• Essential Knowledge Areas • Realistic Expectations for Monastics • The Balance Article

A central theme of her narrative is the ongoing negotiation between her monastic and chaplain identities, as reflected in her struggles with professional boundaries, emotional expression, and the appropriate use of Buddhist teachings. Her "fundamental puzzle"—how to be both a good monastic and a good chaplain—has no final resolution but requires continuous attention and adjustment.

Through CPE, Lynn discovered dimensions of herself that monastic training had suppressed. The recovery of tears, the awareness of feelings, the ability to be present with patients' emotions—these became gifts that enhanced rather than diminished her practice. She now questions whether traditional monastic training's emphasis on equanimity may sometimes mask emotional disconnection rather than representing genuine freedom.

In clinical practice, Lynn applies Buddhist wisdom without imposing Buddhist terms. She teaches meditation adapted to each patient's unique situation, draws on compassion that patients perceive as "positive energy," and serves everyone regardless of religious background. Her bodhisattva vow to serve all beings extends naturally to the hospital setting.

Lynn's vision for training Buddhist chaplains includes cross-cultural psychology, understanding of other religions, and genuine practice of meditation. She gives practical advice for monastics entering the field, recognizing the difficulties but affirming the

wonderful rewards. An article framing chaplaincy as a bodhisattva practice helped her resolve doubts and continues to inform her understanding.

And perhaps most important of all, Lynn learned to set boundaries, the skill she originally identified as her biggest weakness. From the painful lesson of the transferred patient, she now understands that professional boundaries are not barriers to compassion but structures that enable sustainable service. She can say no to patient requests for follow-up, refuse gifts, and maintain appropriate distance—all while bringing full presence to each encounter.

Her reflection on the eighty-seven-year-old patient who insisted she should not die captures the internal negotiation that continues: "That moment. On my little Buddhist nun heart, I truly want to say, 'Dear, you are 87 years old, and you told me you don't want to die.' You want to live forever. That does not make sense, right? Life is suffering…" (L 48:30–49:00). The thought arises from her Buddhist understanding, but she does not speak it. Instead, she stays with the patient's fear, bearing witness without imposing teaching.

This is the integration Lynn has achieved: not the elimination of her Buddhist perspective but its disciplined application in service of the patient's needs. The "little Buddhist nun heart" remains, but it speaks only when invited, teaches only when asked, and offers its wisdom not as doctrine but as presence. In this, she models what Buddhist chaplaincy at its best can become—a way of being that honors both tradition and context, both monastic formation and clinical professionalism, both the bodhisattva's vows and the chaplain's boundaries.

Case 6: Wynn – Planting the Seeds

Participant Background and Context

Wynn is a Chinese Mahāyāna Buddhist nun with extensive academic training across multiple countries. She was ordained as a monastic in 1998 and graduated from Buddhist college with a BA in 2003. After serving in a temple for several years, she pursued a master's degree in Sri Lanka, then arrived in the United States in 2012 to study at the University of the West, where she completed another master's degree and was working on her doctoral dissertation at the time of the interview (W 1:29–2:47).

Her path to CPE was shaped by both necessity and curiosity. She completed her CPE two years before the interview at Children's Hospital Los Angeles, a distinctive setting that made her experience unique among the participants in this study. Her motivation for choosing CPE was twofold: "The first reason is that it's a requirement *[laugh]*… I'm also very curious, so I want to get this experience. That's the reason" (W 3:00–3:32). Her choice of a children's hospital was connected to her dissertation research: "Because my dissertation is going to be written for children and teenagers. So, I want to get some more connections or more conditions to connect with that age group" (W 4:43–5:37).

What distinguishes Wynn's narrative is its honest ambivalence about the value and impact of chaplaincy work. While she acknowledges the potential for learning and growth, she also poses probing questions about the true benefits of brief hospital encounters for patients and the ultimate impact of the "seeds" planted through CPE visits. Her metaphor of Buddhism as a "gem" that patients may not have the energy to recognize

captures a central tension in her experience: the gap between what Buddhism offers and what patients in crisis can receive.

The Negotiation of Monastic Identity in Clinical Space

The Robe as Site of Struggle

Like several other participants, Wynn experienced conflict over whether to wear her monastic robe in the hospital. Her supervisor asked her to change her monastic clothes, creating a prolonged negotiation:

> At the beginning, I was like… I discussed with him for a few weeks before I decided. Actually, I changed the clothes, but they were not lay clothes. I changed it to maybe like Japanese monastic clothes. I don't know why they can accept Japanese monastic clothes but don't accept Chinese monastic clothes. (W 6:27–7:47)

This compromise, choosing Japanese monastic robes as a middle ground, shows how arbitrary the expectations of institutions are. Wynn's comment that the hospital accepted one form of monastic attire but rejected another indicates how such policies may reflect cultural familiarity rather than a consistent principle about religious attire in clinical settings.

Nonetheless, her underlying belief is, "I feel that no matter what I change, I'm still monastic" (W 7:47–8:00). This statement suggests that identity is not just about how one looks and therefore helped her meet the institution's expectations while maintaining her sense of authentic self.

Patient Responses to Monastic Appearance

Because of her monastic appearance, Wynn said, people often assumed she was there to talk about religion, and some patients outright rejected her.

> When they see you as a monastic, they will think, oh, you're coming to talk about religion. So, some people will reject you. So just tell them we don't talk about religion; we just talk about counseling or psychology. So that will be more helpful. (W 7:48–8:43)

This is a pragmatic response to patient resistance, explicitly disavowing religious purpose in order to gain entry. She reinterprets her work in psychological terms, rather than religious ones, which assumptions about proselytizing might otherwise preclude, and creates an opportunity for connection.

Emotional Vulnerability in the Face of Rejection

Wynn is honest about the emotional impact of patient rejection. When asked about confidence in clinical visits, she responds:

> That's hard to summarize in one word. Some people are very easy to talk to, so you'll feel comfortable, and you will feel confident. But if some people reject you and show an unhappy face when you come, of course, you will feel something wrong with your emotions too. (W 9:09–10:00)

This acknowledgment that rejection affects her emotionally—that she is not impervious to patients' "unhappy face"—reflects the human vulnerability beneath the professional role. Her comfort and confidence are not stable traits but fluctuate with each encounter.

The Distinctive Context of Children's Hospital

Working with Families, Not Children

Wynn's CPE experience at the children's hospital was unique among participants, and she notes a distinctive characteristic of this setting:

> Because the children almost don't talk too much. Because when they are sick, and most of the time, we only talk with the family, not the children. (W 6:03–6:20)

This observation shifts the focus of chaplaincy from direct patient care to family support. When the identified patient is a child who may be too ill, too young, or too overwhelmed to engage, the chaplain's primary interlocutors become parents, grandparents, and other family members. This requires different skills and sensibilities than adult chaplaincy—an ability to hold space for familial distress and to address the spiritual needs of those who are suffering vicariously through their child's illness.

Brief Encounters and Limited Connection

The children's hospital context also shaped the nature of relationships Wynn could form with patients and families. She reflects generally on hospital chaplaincy:

> We will not see them for a long time; we will only stop by a few times. And most of the patients don't have the… because when we get a connection after a few visits, maybe we have only just started to go to the big connection. Maybe they have already checked out. It's very hard. (W 12:15–13:35)

The challenge is especially acute in a children's hospital, where stays can be unpredictable, and families need to focus on the medical needs of the child. The chaplain must find ways to be present and supportive within these constraints, accepting that "big connections" are often unattainable.

The Role of the Spiritual Caregiver

Chaplain as Counselor

When asked about her role as a spiritual caregiver, Wynn asks, "Can I summarize as a counselor?" (W 12:15–12:30). This framing emphasizes the therapeutic, listening dimensions of chaplaincy over explicitly religious functions. It aligns with her strategy of telling resistant patients that she is there to talk about "counseling or psychology" rather than religion.

The counselor role, Wynn says, is one of listening, observing, and being present. It doesn't have to impose religious frameworks or teachings but meets patients where they are. This view of chaplaincy as relational rather than instructional reflects the core values of CPE.

The Limits of Hospital-Based Care

Wynn's narrative also evidences an awareness of the limitations of hospital chaplaincy. Relationships are necessarily brief; continuity is disrupted by discharge; deep connection is often elusive. She honestly admits that "it's very hard" to achieve meaningful connection within these constraints, which suggests a realistic assessment of what chaplaincy can and cannot accomplish.

This realism does not lead to cynicism but to a focused effort to do what can be done within the available time and circumstances.

The Integration of Buddhist and Psychological Frameworks

Observation as Bridge

When asked about the advantages of CPE for Buddhist monastics, Wynn highlights the opportunity to reflect on Buddhist learning through clinical observation:

> When talking to the people in the hospital, you can feel their emotions. Actually, when they speak, you can, like what we learned in class about psychology or something. I think that is also a kind of guide for us on how to observe people's situations and use what we learned. And most importantly, it is to observe the beginning. How to observe that will be very helpful. (W 14:30–15:36)

Observation serves as a bridge between classroom learning and clinical practice. The skills of noticing emotions, reading between the lines, and gathering information about family systems (such as through genograms or "Family Tree" exercises) become

tools for understanding patients' situations and determining how to proceed (W 15:52–17:15).

Seeing Buddhist Truths in the Hospital

Wynn notes that Buddhist concepts are not abstractions to be applied to clinical situations but descriptions of what one can directly observe: "Actually, we can see all the situations, like suffering, emptiness, and impermanence, in a hospital very easily" (W 19:16–19:30).

The hospital is not a place where one must find ways to introduce Buddhist teachings; it is a place where Buddhist teachings are visibly, palpably true. Suffering is evident in every room; impermanence is demonstrated by every discharge and death; emptiness—the insubstantiality of what we cling to—is revealed in the fragility of patients' hopes and plans.

Meditation as Clinical Practice

Wynn confirms that she led meditation with patients, both individually and in groups. She describes guiding families together in the meditation room and offering breath meditation to those new to practice (W 23:24–24:29). She notes that meditation has become "more popular" in society, making patients more open to receiving it: "Some people will say, 'Oh, I've heard that but I never practiced, and now I have a chance to practice; please guide me'" (W 25:20–25:38).

When patients show interest in Buddhism, Wynn is willing to share teachings selectively. She focuses on "the Eightfold Paths, Four Noble Truths, some basic doctrine of what the Buddha taught, something like kindness" (W 26:11–27:00). She prefers to emphasize compassion and wisdom rather than suffering: "I'm not used to talking about

suffering a lot; maybe tell them how to become wise people. That's the way of the Buddhist teaching. Kindness and wisdom will be of most importance for us" (W 26:30–27:00).

The Question of Value and Impact

The Gem and the Stone

Wynn's most distinctive contribution to this study is her honest questioning of whether brief hospital encounters truly benefit patients. She uses a striking metaphor:

> Buddhism is a kind of gem. But for the people, they don't have the energy to take that gem; we cannot push them to take what they need, just when they need… a gem, but they don't. They cannot recognize how valuable that is. (W 31:58–33:30)

The hospital patient, exhausted by illness, overwhelmed by medical procedures, and depleted by emotional stress, may not have the capacity to recognize or receive the "gem" of Buddhist wisdom. The chaplain offers something precious, but the patient may lack the energy to take it in.

This leads to a searching question: "How can we continue to guide them in a Buddhist way? That is the problem. We only do our best, and maybe they only have a stone impression of Buddhism and they check out" (W 33:30–34:30). The contrast between "gem" and "stone" captures the gap between what Buddhism offers and what patients may actually receive—not the full treasure, but at best an impression, a trace.

The Seed Metaphor

Wynn acknowledges the common Buddhist framing of such work as planting seeds: "Of course, we can't say, 'Oh, we spread our seeds, Buddhist seeds, in the society.' That's also okay." But she immediately adds: "But actually, it's very hard. Long way to go" (W 34:30–35:00).

This ambivalence—accepting the seed metaphor while noting its limitations—reflects an honest assessment of the gap between aspiration and outcome. Seeds may indeed be planted, but one rarely sees them grow. The chaplain works in faith that something may eventually bear fruit, without the satisfaction of witnessing it.

The Question of Helpfulness

Wynn's questioning goes deeper: "I just feel that what we did, what we do, and what we try—is that very helpful or not?" (W 35:54–36:30). She wonders whether the time spent might be better used elsewhere and whether patients actually receive anything of value:

> We can't spend our time just saying, "Oh, I spent this time for people to know we are Buddhist; we have a Buddhist world," you know, so we need to do something to help them directly, or just like we throw our gem, we hope some people can get it. We hope that what we spend our time on is valuable for us and for other people too. If we spend the time, but they get nothing, why do we spend time? (W 36:00–37:00)

This is not a rejection of chaplaincy but an honest inquiry into its effectiveness. The question, "Why do we spend time" if patients "get nothing," is a challenge to complacent assumptions that any encounter is automatically beneficial. It demands evidence—or at least grounded hope—that the work matters.

The Limitation of Hospital-Based Care

Wynn identifies a structural limitation of hospital chaplaincy: care ends at discharge. For patients who become genuinely interested in Buddhism through her visits, there is no way to continue the connection:

> I have some patients; after a few visits, they started to be interested in Buddhism. But after they leave, they check out, we have no way to connect with them, like we cut off our connection. That is a pity. And we tried our best, and when they really needed it, Buddhism, and we stopped. (W 39:45–40:30)

This contrasts with counseling, where appointments can continue after discharge, and with temple-based practice, where ongoing relationships are possible. Hospital chaplaincy, by its nature, is episodic and brief. The moment of genuine opening may coincide with the end of the encounter, leaving both chaplain and patient with a sense of incompleteness.

The Value and Limitations of CPE for Monastics

Interfaith Learning as Primary Benefit

When asked about the value of CPE for Buddhist monastics, Wynn identifies interfaith exposure as a key advantage:

> There are not many monastics, and not even any Buddhists in the CPE there. So, what we can get the advantage of is—we can get the chance to know how people… how the other religion, or, we can say, other religious people's perspectives… and when we conquer the same situation, how we… how different it is for us to view the same question. (W 27:43–28:30)

Group meetings with peers from different traditions provide "a kind of chance for us to open our eyes" (W 28:30–29:00). This exposure to diverse religious perspectives on shared clinical situations is something monastic training alone cannot provide.

The Environmental Limitation for Deep Practice

Wynn also identifies a limitation of hospital-based work for monastics seeking deep Buddhist practice:

> Because in the hospital, we only practice something very basic. Because for Buddhism, we need to go to something released or something… if you want to get a deep meditation practice or something, it is impossible to get this… it is not a good environment for us to do that. (W 29:52–31:00)

The hospital, with its constant interruptions, urgent needs, and focus on basic presence, is not conducive to advanced practice. What one can offer is "better basic

guiding for people to know what Buddhism tastes like in the hospital" (W 30:30–31:00). This is valuable work, but it is not the same as the deep practice possible in monastic settings.

Right View as Clinical Resource

When asked about Buddhist frameworks for clinical training, Wynn emphasizes Right View from the Eightfold Path:

> In a hospital, I feel that we can give the patient what we can provide our service for, maybe for the Right View. Because normally when people stay in the hospital, they will feel that they will lose their positive view or energy, and sometimes they will feel sad. So, when they stay in a bad emotion, we still can give them some right view to provide them with… to guide them with the right thought to give them hope. (W 31:58–33:00)

This application of Right View is not about teaching Buddhist doctrine but about helping patients reconnect with perspective, hope, and positive energy in the midst of despair. It is a practical, accessible expression of Buddhist wisdom that meets patients where they are.

Summary

Wynn's narrative offers a distinctive voice in this study—one marked by honest questioning about the value and impact of hospital chaplaincy. Her experience at a children's hospital—working primarily with families rather than pediatric patients—gave her a unique perspective on both the constraints and possibilities of clinical spiritual care.

To present these themes more clearly, the table below summarizes the superordinate and subordinate themes that emerged from the analysis of Wynn's interview, offering a clear and organized view of the thematic structure underlying her narrative.

Table 8: Wynn's Personal Experiential Themes

Superordinate Themes	Subordinate Themes
• The Negotiation of Monastic Identity in Clinical Space	• The Robe as Site of Struggle • Patient Responses to Monastic Appearance • Emotional Vulnerability in the Face of Rejection
• The Distinctive Context of Children's Hospital	• Working with Families, Not Children • Brief Encounters and Limited Connection
• The Role of the Spiritual Caregiver	• Chaplain as Counselor • The Limits of Hospital-Based Care
• The Integration of Buddhist and Psychological Frameworks	• Observation as Bridge • Seeing Buddhist Truths in the Hospital • Meditation as Clinical Practice
• The Question of Value and Impact	• The Gem and the Stone • The Seed Metaphor • The Question of Helpfulness • The Limitation of Hospital-Based Care
• The Value and Limitations of CPE for Monastics	• Interfaith Learning as Primary Benefit • The Environmental Limitation for Deep Practice • Right View as Clinical Resource

The central tension in her narrative is between the aspiration to offer something truly valuable—the "gem" of Buddhist wisdom—and the reality that patients in crisis may not have the energy to receive it. She accepts the metaphor of planting seeds but questions whether the seeds ever grow, whether the "stone impression" patients receive is truly helpful, and whether the time spent might be better used elsewhere. These are not cynical questions but honest inquiries that demand attention from anyone serious about the effectiveness of spiritual care.

Her negotiation over monastic robes—resisting her supervisor's request, compromising by wearing Japanese robes, and asserting that "no matter what I change, I'm still monastic"—reflects a quiet confidence in core identity that transcends outward appearance. Likewise, her choice to tell resistant patients that she is there for "counseling"

or “psychology” rather than religion shows a pragmatic adaptation without loss of authenticity.

Wynn’s application of Buddhist frameworks is subtle and patient-centered. She observes suffering, impermanence, and emptiness directly in the hospital without needing to name them. She offers meditation adapted to patients’ capacity, shares basic teachings when interest arises, and emphasizes Right View as a way to restore hope. She understands that deep practice is not possible in the hospital environment, but basic guidance can offer patients a “taste” of Buddhism.

Her most significant contribution to this study is her questioning of chaplaincy’s effectiveness. The question of “why we spend time” if patients “get nothing” presents a challenge that every chaplain and every training program must confront. Her proposed solution—finding ways to continue care after discharge and connecting interested patients with ongoing resources—points toward a more comprehensive model of spiritual care that bridges hospital and community.

In Wynn’s narrative, we see a monastic who entered CPE partly by requirement, partly by curiosity, and emerged with both learning and questions. She values the interfaith exposure, the opportunity to observe and practice, and the chance to offer basic guidance. But she also sees clearly the limitations of brief hospital encounters and wonders whether more could be done. Her open ambivalence, which neither dismisses nor idealizes chaplaincy, offers a useful lens through which to view the potentials and constraints of Buddhist participation in CPE.

Case 7: Mona – From Knowing to Doing

Participant Background and Context

Mona is a Korean Buddhist nun who was ordained at age nineteen and had been a monastic for twenty-two years at the time of her interview. Her path to CPE was notably different from other participants in this study—driven not by religious calling or academic requirement but by the practical need to strengthen her English language skills.

When she first arrived in the United States, her goal was to pursue a PhD in psychology. However, recognizing that her English was "not good enough," a friend suggested she complete another master's degree. She had already earned an MA in Buddhist Counseling Psychology, so she chose to pursue a Master of Divinity (MDiv) degree. At that time, she "had no idea about CPE at all," and it was "not interesting" (to her). It was only through the MDiv studies that she learned about chaplaincy and decided, "Okay, then I want to become a chaplain. So that's why I do the CPE" (M 0:00–1:33).

When asked whether her motivation was connected to Buddhist practice, compassion, mission, or vocation, Mona's response was unequivocal: "It is not my case, not at all… Later I find that it is a good match. Later, I understand what CPE is. After that, but not before. No, not at all" (M 1:33–2:00). Her narrative is unique in that she is willing to admit that her motives were initially instrumental in that she saw CPE as a means to improve language skills and not spiritual formation. Her perspective offers a unique view on the process of finding value even when it is not initially sought.

Mona completed four units of CPE, gaining extensive clinical experience. Her training was in a clinical setting (rather than military or university chaplaincy), where she met "a lot of patients" and developed skills in deep, empathic listening (M 2:00–3:30).

The Discovery of Value Through Practice

From Instrumental Motivation to Genuine Appreciation

Mona's narrative is distinctive for its frank acknowledgment that she entered CPE without any sense of calling or even interest. Her initial motivation was purely pragmatic: "to improve my English" (M 1:00–1:33). This sharply contrasts with participants such as John, who viewed chaplaincy as "living the Dharma," or Lynn, who perceived it as a practical application of Buddhist learning.

Yet despite this instrumental beginning, Mona came to genuinely value the training. When asked about the program, she responds enthusiastically: "Really good, CPE; I learn a lot" (M 2:00–2:15). The learning she describes is substantial: how to listen deeply, how to understand patients' perspectives, and how to work with specific populations, including cancer patients, LGBTQ patients, and dying individuals (M 2:15–3:30).

Her trajectory—from disinterest to appreciation—suggests that CPE's value can be discovered through practice even when not initially recognized. This has implications for introducing CPE to Buddhist monastics who may be skeptical or uncertain about its relevance.

The Integration of Knowing and Doing

Mona articulates the relationship between Buddhist theory and clinical practice in terms of integration. She notes that Buddhism "emphasized compassion" as a theory in textbooks, but before CPE, "I didn't know how to use it properly." Through CPE, she was able to do "more practice and make it together," learning to "compassionately listen to what they say" (M 16:21–17:30).

This integration of theoretical knowledge with practical application is one of the core values of CPE for Buddhist monastics. The abstract compassion becomes concrete; the understanding that "we are all the same human beings" becomes embodied in clinical encounters.

The Negotiation of Dual Identities

Distinguishing Monastic and Chaplain

Mona describes a clear developmental trajectory in her understanding of the relationship between her monastic and chaplain identities. Initially, she struggled to understand how to distinguish her identity as a Buddhist nun from that of a chaplain. Over time, she achieved clarity: "Now I clearly distinguish that the CPE chaplain and monastic are totally different, really different" (M 11:08–11:45).

The distinction she draws is functional and behavioral. A chaplain is "more like a listener and does not fix it or judge it at all." Patients expect a chaplain to refrain from giving advice. In contrast, when she meets Buddhist patients, "they ask me to give them advice" and expect her to function "as a Buddhist nun" (M 11:45–12:30).

This clear differentiation allows her to shift roles appropriately, depending on the patient's needs. "If the patient wants me to do as a Buddhist nun, then I provide that, but if they just see me as a chaplain, then I just do the chaplain role" (M 12:30–12:55). The ability to hold both identities and deploy them according to patient need represents a sophisticated integration.

The Chaplain as Listener, Not Fixer

Mona emphasizes the non-directive nature of chaplaincy repeatedly. The chaplain's role is to listen, avoiding fixing, judging, or advising. This is a fundamental

departure from the standard monastic-lay relationships in which monastics often act as teachers and guides to give direction and instruction.

She notes that even the term "chaplain" carries problematic connotations: "Here, in the United States, in our clinic, chaplain—we use the term 'chaplain,' right? But we don't like the term; 'chaplain' comes from the Catholic… The term is also not good for explaining who I am or what the chaplain's role is" (M 32:40–33:15). This linguistic discomfort reflects the ongoing negotiation between inherited categories and lived experience.

The Obstacle of Visible Monastic Identity

Mona identifies her visible identity as a Buddhist nun—her shaved head and monastic appearance—as "a kind of obstacle" in clinical practice. This is particularly acute with Korean Christian patients, who "have a bias about Buddhist nuns" rooted in Korean cultural and religious dynamics (M 13:21–14:32).

She explains the nature of this bias by stating that Korean Christians "think we worship the Buddha; they think it is wrong. So, that's why they feel like we are very pitiful, very poor; they have to help us. So, they want to convert us because they feel like we are really, really not in a good position right now" (M 15:06–15:54). This perception—that Buddhist monastics are objects of pity in need of conversion—creates a significant barrier to establishing chaplain-patient relationships with Korean Christians.

Mona notes that this dynamic is specific to Korean Christians and does not apply to Korean Buddhists or to non-Korean patients. It represents a cultural-religious intersection that complicates her work in ways that chaplains from majority traditions may not experience.

Learning Through CPE

The Content of CPE Learning

Mona provides a detailed account of what CPE taught her. The program focused on "how to listen to patients deeply and with empathy" (M 2:00–2:30). But listening was not just about communication skills; it was about understanding the patient's perspective: "If a patient has cancer, then how do we deal with that patient? Or LGBTQ patients, if I meet them, how do we understand their side?" (M 2:30–3:30).

The curriculum included study of specific populations and situations: cancer patients, LGBTQ patients, dying individuals, and hospice care. This education extended beyond mere communication skills to include the concept of "understanding the patient side," which she refers to as learning to "put yourself in other people's shoes" (M 3:30–4:16).

Equally important, CPE focused on self-understanding. Through tools like the Enneagram, MBTI, and family lineage exploration, students learned "who I am." The program aimed not only "to understand other people but at the same time to understand ourselves, myself" (M 4:16–5:13).

Peer Learning and Language Support

Mona's relationship with her cohort was characterized by mutual support. Her English language limitation was a significant challenge: "My English is always challenging, so hard," and she relied on peers to help her understand patients:

> This morning, I went to my patient, and she explained something, but I couldn't understand what the meaning really was… So I went back to the office and then asked my peers, "What's the meaning?" And then they explained what the patient meant. (M 6:30–7:30)

This support was reciprocal. Peers asked her about Buddhist chanting, and she shared her knowledge with them. The office became a place of cross-cultural and interfaith learning, a site of inquiry and depth of understanding (M 7:30–8:00).

Self-Evaluation Through Feedback

Mona explains that her way of evaluating her performance in CPE is based on feedback: "Whenever I finished the CPE program, I got the evaluation paper. So I evaluated the paper. So if I got good feedback, then I felt I did well" (M 5:35–6:00). Through four units, she improved based on feedback, ultimately achieving "really good grades or full score" (M 6:00–6:15).

This external validation was important to her sense of accomplishment. The improvement trajectory—from initial challenges to strong performance—reinforced her learning and built confidence.

The Cultural and Religious Dynamics of Korean Christian Encounters

The Bias Against Buddhist Nuns

Mona's experience with Korean Christian patients reveals a specific cultural-religious dynamic that is not present in her work with other populations. She estimates having met "maybe five or six people until now" in her clinical work, and all of them exhibited bias: "all Korean Christians had a bias about Buddhist nuns" (M 14:05–14:39).

The nature of this bias is rooted in Korean religious history and the competitive relationship between Christianity and Buddhism in Korea. Korean Christians view Buddhist practice as "wrong" because Buddhists "worship the Buddha." This theological judgment leads to a paternalistic attitude: Buddhist nuns are considered "very pitiful, very poor," and in need of help and conversion (M 15:06–15:40).

Navigating Bias in Clinical Practice

For Mona, this bias creates an obstacle that she must navigate in patient visits. This bias specifically targets her identity as a Buddhist nun, unlike the general patient resistance that all chaplains may encounter. The patient's rejection is not about chaplaincy in general but about who she is specifically.

She doesn't offer techniques for getting around this bias, suggesting it could be a barrier that some patients just can't get past. The presence of culturally specific resistance suggests the added burden faced by chaplains from minority traditions who not only confront resistance to spiritual care in general but also specific prejudice against their tradition.

The Application of Buddhist Concepts in Clinical Practice

Selective Discussion of Buddhist Teachings

Mona is selective about when and with whom she talks about Buddhist ideas. She distinguishes among patients based on their religious orientation and readiness:

> I can share those topics with those who are getting ready to die, people who die, or prepare for dying; then I will discuss that, especially with those who believe in the next life. If they believe they will go to heaven, no need to discuss at all. Not interesting at all. Why? After I die, I will go to Jesus. I don't care about anything. But if the people are non-religious or Buddhist or spiritual people, I discuss with them… like emptiness and impermanence. (M 18:13–19:30)

This discernment reflects clinical wisdom: different patients have different needs and different frameworks for understanding their experience. Imposing Buddhist concepts on a Christian patient who expects to "go to Jesus" would be inappropriate and unhelpful.

Addressing the "Why" Question

When patients ask why they are suffering—particularly when facing repeated cancers or unrelenting pain—Mona engages them in discussion about Buddhist perspectives on suffering. She describes a patient who "continuously has cancer" and "wanted to know why he has so much suffering" (M 19:30–20:17). In such cases, she shares Buddhist understandings of suffering, impermanence, and emptiness.

However, she distinguishes between discussing impermanence with those preparing to die and discussing suffering with those in active pain. The timing and focus of teaching matter: "When people die or prepare to die, I will talk about impermanence… Suffering is still alive, still alive, but they have so much cancer, so much pain, and then I discuss something" (M 20:29–20:55).

Compassion as Foundational

At the core of Mona's Buddhist application is compassion. She returns to this point repeatedly: "Buddhism has emphasized compassion" (M 16:21–17:00). The Buddhist teaching that "all we are equal" helps her when explaining to patients why they experience suffering (M 17:30–17:54).

Compassion is not merely a feeling but a practice—the "compassionately listen[ing]" that she learned to integrate through CPE. Her Buddhist formation provided the theoretical understanding of compassion; CPE provided the practical skills to embody it in clinical encounters.

The Transformative Value of CPE for Buddhist Monastics

Learning Equality Through Practice

Mona offers a powerful illustration of how CPE transforms monastic understanding of self and others. She recounts an experience with a Buddhist patient who also had her own "Venerable" (monastic teacher) visiting. The contrast between the two approaches was striking:

> They have no idea what CPE is; they don't have any education about chaplains. So, my support approach is so different. So, they are like, you know, the Venerable is higher than laypeople; Venerables are high. So, when they meet the patient, he/she, like, demands, "You should take medicine well, you listen to the doctor well, you do that, you do this…" Everything is control, control, control, you know? But I got the CPE education. It is not the chaplain's role; the chaplain is to listen to what the patient says. (M 21:53–23:30)

This contrast reveals the fundamental shift that CPE enables: from a hierarchical model in which the monastic directs and controls to an egalitarian model in which the chaplain listens and accompanies. Mona notes that through CPE, "The Buddhist nuns will know that we are equal. We are a little bit lower because we have to support them, and we encourage them to have a bright worldview by listening to their story" (M 23:30–24:33).

This reframing—seeing oneself as "a little bit lower" rather than higher—represents a profound transformation in monastic self-understanding. It does not contradict monastic identity but reorients it to service and accompaniment rather than direction and control.

The Challenge of Interfaith Openness

The potential downside or challenge of CPE for Buddhist monastics is that they need to be accepting of other religions, Mona points out. In clinical practice, Buddhist

chaplains must learn to pray in the language of other traditions, participate in Jewish and Christian rituals, and understand the basics of multiple faiths:

> If the Buddhist nun, maybe… Oh, Buddhism is perfect; we should practice Buddhism. I only focus on practicing Buddhism. But if you do the CPE more often, you have to participate in, you know, Jewish, Christian, and Catholic rituals. And we should know their rituals, at least the basic ones, how to pray for the patient who has their religion, and we have to be more open. So, maybe it is really challenging for some Venerables: Why do we have to learn? (M 24:37–26:01)

This challenge is real: monastics who view Buddhism as "perfect" and sufficient may resist learning about and participating in other traditions. Yet Mona affirms that such openness is necessary: "That is really what we have to learn" (M 26:00–26:10).

The Risk of Identity Confusion

Mona also notes that CPE can sometimes lead to confusion about identity: "Maybe confused about who you are" (M 24:37–25:00). Moving between roles—monastic with Buddhist patients, chaplain with others—requires clear boundaries and self-awareness. Without these, the multiple demands and expectations can become disorienting.

This risk is managed through the kind of clear differentiation Mona has developed: understanding when to function as a monastic and when to function as a chaplain and being able to shift between them based on patient need.

The Interfaith Imperative in Buddhist Chaplaincy Training

Resistance to Sectarian Training

When asked about developing clinical Buddhist chaplaincy training programs, Mona expresses strong reservations about any approach that would emphasize Buddhist identity over interfaith competence. Her response is emphatic:

> I'm really not just based on… just follow what they do right now. Because they also do not have any specific religious tradition, they do not follow any religious tradition and just make more subjects interfaith. I think it is better just to follow their interfaith; it is my opinion. Not training like a Buddhist chaplain, they do not train as a Christian chaplain or a Catholic chaplain. Buddhist chaplain, the education, CPE, is just interfaith, right? (M 27:00–28:00)

For Mona, the essence of CPE is its interfaith character. Training that would emphasize Buddhist identity risks losing this essential quality. She argues that chaplains must learn to be "neutral to the patient," and for that, they need "general CPE education" rather than sectarian training (M 28:48–29:14).

The Danger of Limited Perspective

Mona elaborates on the danger of Buddhist-specific training: it would produce chaplains who have "only their view, Buddhist view, and Buddhist worldview, but they do not know the other traditions." In clinical settings where chaplains "will meet various religious patients," such a limited perspective would be inadequate: "We have very, very limited thought to understand other religious perspectives" (M 30:21–31:44).

Her concern is practical and patient-centered. The goal is not to produce good Buddhists but to serve patients of all traditions effectively. Training that focuses too narrowly on Buddhism would fail to prepare chaplains for the religious diversity they will encounter.

Knowing Ourselves to Be Open to Others

Mona offers a constructive vision for how Buddhist identity and interfaith competence can coexist: "We know ourselves so well, so well about ourselves. So more open to the other religions" (M 33:50–34:10). A deep grounding in one's own tradition leads to openness to others rather than its foreclosure.

This formulation resolves the apparent tension between Buddhist identity and interfaith practice. The chaplain who is secure in their own tradition can engage others without threat or defensiveness. It is not necessary to abandon Buddhist identity to serve non-Buddhists; rather, a well-formed Buddhist identity becomes the foundation for authentic interfaith presence.

The Problem of Language

Mona notes that even the terminology of chaplaincy carries Christian associations. "Chaplain" comes from Catholic tradition, and "CPE," with its "pastoral" language, is similarly Christian in origin. This linguistic inheritance creates ongoing discomfort: "We know that term is wrong, because… it is like a Christian term" (M 32:40–33:45).

This awareness of linguistic and conceptual inheritance points to more profound questions about whether and how Buddhist chaplaincy can fully inhabit categories shaped by other traditions. Mona does not resolve this tension but names it as part of the ongoing negotiation of Buddhist participation in a historically Christian field.

Summary

Mona's narrative offers a distinctive perspective among the participants in this study. Alone among them, she entered CPE without any sense of calling, mission, or even interest—driven initially by the practical need to improve her English. Yet through the training, she discovered genuine value and developed into an experienced chaplain who completed four units and integrated her learning deeply.

To show the structure of these themes more clearly, the table below presents Mona's personal experiential themes derived from the case analysis, offering a clear and organized view of the thematic structure underlying her narrative.

Table 9: Mona's Personal Experiential Themes

Superordinate Themes	Subordinate Themes
• The Discovery of Value Through Practice	• From Instrumental Motivation to Genuine Appreciation • The Integration of Knowing and Doing
• The Negotiation of Dual Identities	• Distinguishing Monastic and Chaplain • The Chaplain as Listener, Not Fixer • The Obstacle of Visible Monastic Identity
• Learning Through CPE	• The Content of CPE Learning • Peer Learning and Language Support • Self-Evaluation Through Feedback
• The Cultural and Religious Dynamics of Korean Christian Encounters	• The Bias Against Buddhist Nuns • Navigating Bias in Clinical Practice
• The Application of Buddhist Concepts in Clinical Practice	• Selective Discussion of Buddhist Teachings • Addressing the "Why" Question • Compassion as Foundational
• The Transformative Value of CPE for Buddhist Monastics	• Learning Equality Through Practice • The Challenge of Interfaith Openness • The Risk of Identity Confusion
• The Interfaith Imperative in Buddhist Chaplaincy Training	• Resistance to Sectarian Training • The Danger of Limited Perspective • Knowing Ourselves to Be Open to Others • The Problem of Language

Her central contribution is the clear distinction she draws between monastic and chaplain identities. For Mona, these are "totally different" roles that require different behaviors and elicit different expectations from patients. She has learned to shift between them fluidly based on patient need—functioning as a monastic with Buddhist patients who seek advice and as a chaplain with others who expect listening without direction.

The contrast she observes between her approach and that of an untrained monastic visiting the same patient is illuminating. The untrained monastic operated from a hierarchical model, "control, control, control," telling the patient what to do. Mona, shaped by CPE, listened and accompanied. This contrast reveals what CPE offers

Buddhist monastics: an alternative model of spiritual presence that is not about directing but about being with.

Mona's experience with Korean Christian patients reveals an additional layer of complexity faced by chaplains from minority traditions. Cultural and religious bias can hinder chaplaincy, as patients' preconceptions about her have nothing to do with her competence. Navigating this requires patience and the ability to accept that some doors will remain closed.

Her views on Buddhist chaplaincy training are notably skeptical of sectarian approaches. She argues forcefully that CPE should remain interfaith, that chaplains need to know other traditions, and that Buddhist-specific training would produce chaplains with "limited thought." The solution is not separate training but deep grounding in one's own tradition combined with openness to others.

This vision—knowing oneself "so well" to be "more open to the other religions"—captures the integration Mona has achieved. She is unmistakably a Buddhist nun, yet she functions effectively as an interfaith chaplain. Her identity is appropriately deployed, affirmed, and held flexibly. The "puzzle" that Lynn described—finding balance between monastic and chaplain identities—Mona has resolved through clear differentiation and role-appropriate behavior.

Her journey from instrumental motivation to genuine appreciation, from identity confusion to clear distinction, from discomfort with other traditions to committed interfaith practice, models a trajectory that other Buddhist monastics might follow. She entered CPE for the "wrong" reasons by some measures—not out of calling but out of practical need—yet she emerged transformed, with skills, self-understanding, and a

capacity for compassionate presence that she might not have developed otherwise. Her narrative suggests that the value of CPE for Buddhist monastics may be discovered in practice, even when not recognized in advance.

Cross-Case Analysis

This section offers an orienting synthesis of the themes that emerged from the interpretative phenomenological analysis of seven Buddhist monastics who engaged in CPE in the United States. While the preceding section (Idiographic Findings) attended closely to each participant's particular lifeworld, honoring IPA's commitment to depth, nuance, and case-by-case meaning-making, this section adopts a more integrative perspective. It summarizes how participants made sense of CPE as a formational and clinical encounter at the intersection of monastic identity, Buddhist doctrine and practice, institutional healthcare culture, and professional chaplaincy expectations. The thematic structure presented here is supported by a multi-layered analytic audit trail: Appendix C (In Vivo Code List) documents participant-near language that served as primary interpretive anchors, Appendix D (Thematic Code List) shows how those in vivo codes were clustered and abstracted into thematic codes, and Appendix E (Code Groups Summary) traces the consolidation of thematic codes into broader code groups that informed the superordinate and subordinate themes. These appendices provide a more detailed catalog of the coding and theme-development process that undergirds the summary offered in this section.

Following IPA principles, this cross-case analysis begins with each participant's individual case before moving toward shared themes. It highlights where participants

converge and diverge, always staying close to their actual experiences. The goal is not to flatten their differences into a single narrative, but to show both the structural conditions and the personal realities that shape how Buddhist monastics engage with CPE—while still honoring the distinct path each one has taken.

The seven participants—John, Dora, Hope, Faye, Lynn, Wynn, and Mona—represent a remarkable diversity of Buddhist traditions (Tibetan Geluk and Nyingma, Chinese Mahāyāna Linji Chan, Korean Buddhist, and multi-tradition training), cultural backgrounds (American, Chinese, Korean, Vietnamese, and cross-cultural), stages of training (from first-unit students to experienced staff chaplains), and clinical settings (pediatric hospitals, trauma centers, cancer centers, children's hospitals, and palliative care units). Despite this diversity, their narratives reveal shared existential and professional challenges that define the Buddhist monastic experience in CPE.

Six superordinate themes emerged across the cases: (1) the negotiation of dual identities, (2) the transformation of emotional awareness, (3) the application and adaptation of Buddhist concepts in clinical contexts, (4) the navigation of cultural and religious difference, (5) the distinctive contributions of Buddhist monastics to chaplaincy, and (6) the vision for Buddhist chaplaincy training. Within each theme, participants' experiences converge in some dimensions and diverge in others, revealing both common structures and individual variations.

The Negotiation of Dual Identities

All seven participants grappled with the tension between their monastic identity and their emerging identity as chaplains. This negotiation took different forms—ranging

from explicit reflection on the differences between the two roles to embodied struggles over attire—but was universally present as a central dimension of the CPE experience.

The Fundamental Puzzle of Two Roles

Lynn articulated what she called the "fundamental puzzle" with particular clarity: "I always find the middle path. I have to be a good monastic first, and I want to be a good chaplain at the same time. I always find my balance. If I really am a wonderful chaplain, sometimes I will lose my monastic identity; it is easy to lose it. But if I am only a good monastic, I may not be a good chaplain" (L 14:00–14:45). This framing of the challenge as a "middle path" is itself Buddhist—she uses the language of her tradition to describe the resolution of a conflict between Buddhist and professional norms.

John, by contrast, experienced no such conflict. When asked about differences or contradictions, he responded, "Absolutely none" (J 13:01). His teachers had affirmed his chaplaincy work as "living the Dharma," providing a foundational validation that prevented the emergence of identity conflict. This suggests that the relationship between the monastic and the chaplain may be experienced as either integrated or tense, depending in large part upon the presence or absence of institutional support within one's tradition.

Dora's negotiation was about the robe as "my skin" (D 21:02). Her supervisor's challenge—"your robe is not you"—initially met resistance but eventually led to experimentation with secular clothes. This embodied negotiation revealed how deeply monastic identity is carried in physical appearance and how its modification can feel like self-loss. Hope, working in a multifaith setting that encouraged full robes, experienced no

such pressure; her ability to wear "full Buddhist monastic authority" (H 10:10–10:20) allowed her to practice without compromising her visible identity.

Wynn's compromise—adopting Japanese monastic robes when her supervisor rejected Chinese robes—revealed the arbitrary nature of institutional expectations. Her observation, "I feel that no matter what I change, I'm still monastic" (W 7:47–8:00), asserted that identity transcends external appearance, even as she complied with institutional requirements.

The Boundary Problem

The concrete manifestation of identity negotiation for several participants was the challenge of setting professional boundaries. Lynn identified this challenge as her "biggest weakness" in CPE training, noting that her natural monastic inclination was to give freely—buying reading glasses for homeless patients, cooking for students, and offering money to those in need. "For me, in a monastic position, it is normal for me, but as a CPE student, of course, it is not a professional working relationship" (L 11:20–12:10).

The conflict over after-hours availability was particularly acute. Lynn described wanting to stay with a crying patient but learning she had to leave: "That's really, really struggling for me. Because as monastics, we work 24 hours, 365 days, right? Anytime, anytime! But that's difficult for me" (L 15:30–16:30). The monastic model of unlimited availability collided with the professional model of scheduled presence.

A pivotal learning moment came when Lynn visited a dying Buddhist patient who had been transferred to another unit without the unit chaplain's permission. At the time, she acted from a nun's duty; later, she recognized this as a boundary violation: "Now I

am really very clear about that boundary. Boundary, very clear" (L 22:30–23:00). This learning—that professional boundaries are not barriers to compassion but structures enabling sustainable service—represented significant growth.

Mona resolved the identity question differently, developing a clear distinction between roles: "Now I clearly distinguish that the CPE chaplain and monastic are totally different, really different" (M 11:08–11:45). This cognitive clarity allowed her to shift functions based on patient need—a monastic with Buddhist patients who sought advice and a chaplain with others who expected listening without direction.

Hierarchical vs. Egalitarian Models

Mona offered a powerful contrast between traditional monastic-lay relationships and chaplaincy relationships. Observing an untrained monastic with a shared patient, she noted the monastic "control, control, control" approach—telling the patient what to do—versus her own listening approach. Through CPE, "The Buddhist nuns will know that we are equal. We are a little bit lower because we have to support them, and we encourage them to have a bright worldview by listening to their story" (M 23:30–24:33).

This reframing—seeing oneself as "a little bit lower" rather than higher—represents a fundamental transformation in monastic self-understanding. John's teachers had already affirmed this orientation, telling him his chaplaincy work was "living the Dharma" (J 1:48–2:04). For others, the shift was more challenging, requiring conscious reorientation.

Divergent Resolutions

Participants arrived at different resolutions to the identity question. John experienced seamless integration, with no perceived contradiction. Lynn found a "middle path" that let her balance both identities, constantly adjusting along the way. Mona made clear functional differentiation, changing roles according to context. Dora discovered that her monastic "wall" of emotional protection needed modification for clinical work. Hope found the multifaith model allowed her to practice with full integrity, her monastic identity honored rather than suppressed.

These divergent resolutions suggest that there is no single "correct" way to integrate monastic and chaplain identities. The optimal resolution depends on individual temperament, institutional context, and the degree of support from one's tradition. All participants agree that CPE raises the question and that some form of integration or differentiation must be achieved.

The Transformation of Emotional Awareness

A striking pattern across multiple narratives was the transformation of participants' relationship to emotion. This took various forms—discovering suppressed feelings, learning to stay with patients' emotions, questioning monastic emotional norms—but was consistently present as a significant dimension of CPE learning.

The Discovery of Tears

Lynn's account of recovering her capacity to cry is perhaps the most dramatic. Having gone "almost 10 more years" without tears, she was challenged by CPE supervisors: "If you do not feel the pain, how can you feel the patient's pain?" (L 19:00–

20:00). Her initial response reflected monastic training: she had "processed all that grief already" through Buddhist practice, viewing events through lenses of impermanence and karma. But the supervisors' persistent questioning led her to imagine others' experiences, and gradually, "I think I still have tears" (L 20:30–21:00). Now she cries at movies and experiences emotions previously inaccessible.

This transformation raises profound questions about the relationship between Buddhist equanimity and emotional availability. Lynn's experience suggests that the lack of tears may not be liberation but alienation—that real compassion involves the ability to be touched by suffering, not just observe it from a distance.

The Discovery of the Wall

Dora's transformation was about finding what she metaphorically called "a wall" she'd built to protect herself from feelings. Her young, emotionally expressive peers served as mirrors: "Their emotions, their story emotions, kind of open my emotions up, and then I found how distant my… how I keep a wall; I build a wall to protect myself and the world" (D 8:30–9:50). This wall, reinforced by Chinese cultural norms and monastic training, had served a protective function but limited her capacity for presence.

Through CPE, Dora came to recognize that her default response to intense emotion was avoidance: "I always try to run away from my emotions, because it's so difficult to stay there. And then it will turn out that it's difficult for me to stay with patients' emotions" (D 11:09–12:10). The clinical setting demanded something different: the capacity to "bear with it, you know, and stay with it; at least leave some space for the kind of emotion" (D 12:30–12:50).

The Question of "No Feeling"

Lynn extended her reflection to question whether monastic training might sometimes produce emotional numbness rather than genuine equanimity. The monk who saw snow for the first time at age sixty and reported "no feeling" became a case study: "You can say, as a monastic, it's right. We do not… our emotions do not wave by following the environment… But as a clinical training, CPE training, I don't think that's the right answer" (L 23:00–23:30).

Her question is profound: If a monastic cannot feel excitement at a first snowfall, how can they understand a patient's feelings when facing loss or novelty? "Then how do you understand the patient's feelings if a patient is experiencing the same things?" (L 23:30–24:00). This questioning does not reject monastic training but seeks integration—emotional awareness without being controlled by emotion.

Cultural Dimensions of Emotional Expression

Several participants noted cultural dimensions of emotional expression. Dora explicitly linked her emotional guardedness to being Chinese: "As an Asian, a Chinese Asian, as a Chinese, I grew up in that kind of culture. We are not supposed to express our emotions" (D 39:36–40:10). The hospital setting required unlearning this cultural conditioning.

Lynn noted the different expectations of emotional expression in monastic versus lay contexts. She can tell laypeople that she feels sad or angry, but she still cannot express these feelings to other monastics. "Then they will tell me, 'Venerable, go to more meditation, do more chanting'" (L 22:00–22:30). This bifurcation—emotional honesty in

some contexts, emotional containment in others—reflects the ongoing negotiation between her two worlds.

The Application and Adaptation of Buddhist Concepts

All seven participants engaged with the question of how Buddhist teachings apply in clinical contexts. They had different approaches, but there were common patterns in terms of which concepts were useful, how they were adapted, and the challenges of translation.

Core Concepts in Clinical Practice

Across participants, certain Buddhist concepts recurred as clinically relevant. Compassion (*karuṇā*) was universally named as foundational. John identified "wisdom and compassion" as the primary Buddhist resources. Compassion was understood as "ultimate compassion to take away suffering from people, if you can" (J 13:01–13:48). Lynn emphasized "compassion, unconditional love, and bodhicitta" as the teachings she draws upon (L 34:30–35:00). Mona noted that Buddhism "emphasized compassion" and that CPE helped her learn "how to use it properly" (M 16:21–17:30).

Impermanence (*anicca*) was also widely cited, though with caution about direct discussion with patients. John named it a core concept (J 16:35–17:10). Hope described teaching patients to "observe the pain when it rises… just like a wave" (H 17:10–18:00). Faye struggled to apply it initially but later found connections through the Lotus Sutra (F 32:30–36:00).

The Four Noble Truths served as an interpretive framework for several participants. Dora applied them to clinical understanding: "There is a lot of suffering in

every room… How can I release… reduce their suffering?" (D 30:10–31:20). Lynn noted that understanding suffering and its causes supports clinical work, though "we do not necessarily make them happy; we do not necessarily get a good outcome" (L 20:30–21:00).

The Challenge of Buddhist Language

A consistent finding across participants was the inappropriateness of using traditional Buddhist vocabulary with most patients. Faye stated directly that terms like "suffering," "emptiness," and "impermanence" are "too big, too hollow"—too abstract and potentially alienating for patients in crisis (F 39:06–39:30). She questioned whether anyone in acute suffering wants to hear such teachings: "They don't need this teaching at that moment" (F 41:00–41:30).

Hope was attentive to the weight of words, noting that "suffering" can feel heavy, so she might ask instead, "What is the issue that you're facing?" (H 22:53–23:20). Lynn developed a clear principle: "I do not talk about these terms with my patient unless they request it or they mention it, yeah, when they mention the Buddhist terms" (L 1:32–2:30). A supervisor's story about wanting to "punch" someone who told her "life is impermanent" after her father's death stayed with Lynn as a cautionary tale.

The solution was not to abandon Buddhist wisdom but to translate it into accessible forms. Hope observed, "I break the Buddhist components down" (H 24:20–25:30). Lynn emphasized using "the content" rather than "the Buddhist terms" (L 34:30–35:00). The teachings are present but offered as invitations rather than instructions.

Meditation as Clinical Tool

Meditation emerged as a primary vehicle for applying Buddhist wisdom in clinical settings. All participants who discussed clinical practice mentioned leading meditation with patients. Wynn described guiding both individual patients and family groups, adapting to whether patients had prior meditation experience (W 23:24–24:29). Dora noted that when conversation was difficult, leading meditation could "build some kind of connection" (D 3:30–4:00).

Lynn offered the most developed account of clinical meditation, drawing on over thirty-two years of personal practice. She emphasized that effective clinical meditation requires more than technical knowledge: "If you have never practiced meditation, that is totally different. Even though you are a native speaker, English is much better than mine. But my leading and your leading, the result is different" (L 41:30–42:00). Her teaching is highly individualized, adapted to each patient's "medical situations, their personalities, and their living environments" (L 42:00–42:30).

For patients on the deathbed who cannot feel their bodies or follow their breath, Lynn improvises creatively: "'Do you know where you are right now?' 'Yeah, I'm in the bed.' And so, you ask, 'Yeah, can you see the shape of your bed? The shape?' 'Yeah, I'm on the single bed.' 'How is your bed?' He said… Okay, now we practice meditation concentrating on this bed" (L 46:30–47:00). This adaptation—using whatever object of concentration is available—draws on Buddhist principles while meeting the patient exactly where they are.

The "Why" Question and Buddhist Resources

Several participants noted the distinctive challenge that Buddhism faces in addressing patients' "why" questions, such as why my child is dying or why bad things happen to good people. Lynn observed that CPE training teaches chaplains to respond, "I really don't have answers for you" (L 31:00–31:30). Yet, "As a monastic, I can tell them why—why this happened. I can tell them, right? I can open the Buddhist scriptures" (L 31:30–32:00).

This creates an ongoing tension. Buddhism offers explanations through karma, causes and conditions, and the nature of existence.[192] Yet clinical training prohibits offering such explanations unless explicitly requested. Lynn noted that this may reflect a difference in resources: Christian chaplains may have "no tools" beyond "God's will," while Buddhists have rich explanatory frameworks that must be withheld (L 32:00–32:30).

In practice, participants developed discernment about when to share Buddhist perspectives. Mona distinguished among patients: those who believe they will "go to Jesus" have no interest in Buddhist teachings; those who are non-religious, Buddhist, or spiritual may be open to discussion (M 18:13–19:30). Such selective sharing respects the patient's autonomy while making Buddhist resources available to those who seek them.

The Challenge of Application

Faye's narrative captured the struggle of applying Buddhist teachings in clinical contexts with particular honesty. When asked about this, she responded: "Actually, I think this question is… it's interesting. This is what puzzles me a lot. In particular, during

[192] Adele Smith-Penniman, "Buddhist Resources in Pastoral Care" (DMin diss., Andover Newton Theological School, 2006).

the CPE program, so I struggled very, very hard" (F 30:02–30:30). The requirement to provide Dharma reflection on clinical encounters felt like an impossible task.

Her breakthrough came later, through a reading of the Lotus Sutra that revealed the Phantom City parable as a template for understanding her role. The guide who creates an illusory city to encourage weary travelers becomes an image of the chaplain who creates temporary refuge for those in distress (F 32:30–36:00). This interpretation, reading through the lens of compassion rather than doctrinal correctness, became a model for how Buddhist texts might be reclaimed for clinical contexts.

Faye's experience suggests that the integration of Buddhist teachings into clinical practice is not achieved once and for all, but instead unfolds over time, requiring ongoing reflection and reinterpretation.

The Navigation of Cultural and Religious Difference

All seven participants, as Buddhist monastics from Asian backgrounds or Westerners trained in Asian traditions, navigated multiple dimensions of cultural and religious difference in their CPE experiences. This navigation took various forms but was universally present as a dimension of their lived experience.

The Experience of Being an Outsider

Several participants articulated feelings of otherness in their CPE cohorts. Faye explained her feelings by saying, "I feel like an outsider. Because, you know, basically I'm an atheist, and no gods or spirits, you know, work the way they would work" (F 17:30–18:30). In a cohort dominated by theistic frameworks, her non-theistic Buddhism placed her outside the shared vocabulary of God, grace, and divine presence.

Dora was the only Buddhist in her cohort of six, with peers significantly younger and more emotionally expressive. She felt the difference acutely: “These emotional people cannot help me to find or discover my own emotions, because as a monastic, we can keep our emotions away from people” (D 8:30–9:00). Yet these same peers, by their emotional availability, helped her discover her own emotional “wall.”

John’s experience was exceptional: his cohort included six Buddhists, creating a supportive environment that mitigated outsider feelings. He recognized this as unusual, noting the interviewer was the only Buddhist in her cohort (J 11:08–11:16). This variation suggests that cohort composition significantly shapes the experience of Buddhist participants.

Linguistic and Cultural Barriers

The language itself was a major problem for those whose first language was not English. Dora talked about the difficulty of dealing with medical terms: “There are a lot of new words in the hospital that I don’t know, like what kind of disease, you know, the names of the diseases” (D 10:20–11:00). Mona relied on peers to help her understand patients: “I went back to the office and then asked my peers, ‘What’s the meaning?’ And then they explained what the patient meant” (M 6:30–7:30).

Faye’s outsider status was compounded by multiple dimensions: “As a foreigner from China, I am in the United States, and I speak different languages. I have… like I know little about the… because, you know, the United States as a Christian country basically, I don’t know much about their Christian theology” (F 19:46–20:30). Linguistic, cultural, and religious differences created a profound sense of exclusion.

The Challenge of Asian Patients

Paradoxically, several participants found that shared cultural background did not automatically facilitate connection. Dora noted that Asian patients often resisted her visits: "They kind of refuse to see me, because they see me… because I guess they are not familiar with chaplains. So, when they see me, it is like, 'Who are you? You're a stranger'" (D 14:53–15:30). In contexts where chaplains are unknown, even a co-ethnic visitor may be perceived as an intruder.

Lynn observed that once Asian patients established a connection, they often sought more personal involvement: "They will treat you as a friend. They will ask for your phone numbers, personal phone numbers, personal email address, and even my temple's address and want to come to visit me" (L 10:30–11:00). This created boundary challenges that differed from those with Western patients.

Faye found that shared language could transcend religious difference: with Mandarin-speaking patients, "the tradition, you know, the religion transcends… nationalities transcend the religion" (F 22:00–22:30). Her visits with a young man from China and his parents became essential support for a family with no one else.

Specific Religious-Cultural Bias

Mona's experience with Korean Christian patients revealed a specific form of religious-cultural bias that other participants did not report. Korean Christians, she explained, "have a bias about Buddhist nuns" rooted in Korean religious history. They view Buddhist practice as "wrong" and Buddhist nuns as objects of pity in need of conversion (M 15:06–15:54).

This created an obstacle that was not about chaplaincy in general but about her specific identity. This issue specifically targeted her identity, unlike the general patient resistance that all chaplains encounter. The existence of such culturally specific resistance highlights the additional burden carried by chaplains from minority traditions.

Learning from Difference

Despite the challenges of difference, participants also identified learning from interfaith exposure as a key benefit of CPE. Wynn noted that CPE provided "the chance to know how people… how the other region, or, we can say, other religious people's perspectives… and when we conquer the same situation, how we… how different it is for us to view the same question" (W 27:43–28:30). Group meetings with peers from diverse traditions provided "a kind of chance for us to open our eyes" (W 28:30–29:00).

Mona's peers helped her understand American patients and provided language support, while she shared Buddhist chanting and perspectives. This reciprocal learning created relationships of mutual support across difference.

The Distinctive Contributions of Buddhist Monastics to Chaplaincy

Participants articulated what they saw as the unique gifts Buddhist monastics bring to clinical settings. These contributions were grounded in Buddhist training and practice, yet served patients of all traditions.

The Energy of Compassion

Lynn emphasized that patients perceive something beyond technique—a quality of presence that comes from genuine compassion. She described a patient who requested follow-up visits specifically because she saw Lynn's "positive energies" even through a

video screen: “I think that energy from my Buddhist training, from my compassionate heart” (L 31:00–32:00).

This sensitivity to energetic presence suggests that what Buddhist chaplains offer transcends techniques and words. The years of meditation and ethical training shape a quality of being that patients perceive and respond to, even across cultural and linguistic barriers.

Meditation Resources for Clinical Settings

Buddhist monastics possess extensive meditation experience that can adapt for clinical use. Lynn has led meditation for staff, established “comfort corners” (meditation rooms) in the hospital, and conducted research on meditation interventions with ICU patients (L 29:00–30:00, 48:00–49:00). Wynn guided both individual patients and family groups (W 23:24–24:29). Dora collected meditation resources for different needs: “meditation for reducing pain… this meditation is helping with your anger and emotions” (D 2:30–3:30).

The adaptation of meditation for clinical contexts requires skill and experience. Lynn emphasized that effective clinical meditation teaching requires personal practice: “You have to practice by yourself. You have to really have a good meditation experience” (L 43:30–44:00). Without this, leading meditation becomes mere recitation.

The Surprise of Open-Minded Tradition

Hope observed that her traditional appearance often triggered assumptions that she would be rigid or unable to understand patients. This became an opportunity for surprise and connection: patients discovered, “Wow, I am so wrong about… you know,

you're so open-minded" (H 26:15–27:30). This openness, Hope reflected, is not a departure from her tradition but an expression of it: "being open-minded is also a path, a part of the monastic practice" (H 27:30–28:00).

The apparent paradox—a traditional monastic who is unexpectedly open-minded—resolves when one understands that openness is itself a Buddhist value. This surprise can become a bridge to connection with patients who might otherwise be guarded.

Serving Beyond Buddhism

All participants emphasized that their service extends to all patients, regardless of religious background. Lynn grounded this in Buddhist vows: "In Buddhism, we can benefit all the people in the world, right? Because we make vows, we will serve all sentient beings, even animals. So why can't we serve non-Buddhists? That doesn't make sense, right?" (L 39:30–40:00).

Buddhist chaplaincy is unique among other traditions that focus on serving co-religionists because of its universal orientation. The bodhisattva vow to serve all beings translates naturally to the hospital setting, where chaplains meet patients of all traditions and none.

The Vision for Buddhist Chaplaincy Training

Participants gave different perspectives on training Buddhist chaplains, what content is necessary, and how Buddhist-specific training compares to established CPE programs. These visions were reflective of their different experiences and roles.

Essential Buddhist Frameworks

Participants were asked what Buddhist principles they thought should be included in clinical training, and they mentioned several core components. The Four Noble Truths were often described as a way to understand suffering and how to end it (Dora, Hope, Lynn, Wynn). The Eightfold Path, especially the Right View, was clinically applicable in helping patients regain perspective and hope (Wynn, Lynn). The Three Tenets of Zen Peacemakers—Not Knowing, Bearing Witness, and Loving Actions—provided a framework for Dora's clinical approach (D 28:07–28:50).

Meditation was universally identified as an essential resource. Dora suggested training in specific meditation techniques for different needs: pain, anger, and relationship issues (D 9:14–9:52). Lynn emphasized that such training must be grounded in personal practice: "Please practice daily. That's very important" (L 41:30–42:00).

Compassion cultivation emerged as a priority. Faye offered a critique of her tradition's emphasis on wisdom (*prajñā*) at the expense of compassion (*karuṇā*): "We tend to talk about the lofty concept of emptiness… but I don't see that we're so enthusiastic about how to cultivate compassion" (F 31:30–32:30). Clinical training, she suggested, should redress this imbalance.

The Debate Over Sectarian Training

A significant divergence emerged among participants regarding whether Buddhist-specific training programs should be developed. Mona expressed strong reservations:

> I'm really not just based on… just follow what they do right now. Because they also do not have any specific religious tradition, they do not follow any religious tradition and just make more subjects interfaith. I think it is better just to follow

> their interfaith; it is my opinion. Not training like a Buddhist chaplain, they do not train as a Christian chaplain or a Catholic chaplain. Buddhist chaplain, the education, CPE, is just interfaith, right? (M 27:00–28:00)

Her concern was practical and patient-centered: Buddhist-specific training would produce chaplains with "only their view, Buddhist view, and Buddhist worldview, but they do not know the other traditions." In clinical settings with diverse patients, such a limited perspective would be inadequate (M 30:21–31:44).

Hope, by contrast, called for Buddhist chaplains to "band together, create a training program, and exert… be a force in itself to break down these paradigms" (H 34:08–34:30). Her vision was explicitly political: to transform CPE programs from their historically Christian assumptions toward something genuinely multifaith.

These positions are not necessarily contradictory. One can advocate for a stronger Buddhist presence and organization while maintaining that training should remain interfaith in content. Mona's concern about "limited thought" speaks to content; Hope's concern about power speaks to structure. A synthesis might involve Buddhists organizing collectively to influence CPE programs while ensuring those programs remain interfaith in orientation.

The Need for Additional Knowledge

Lynn identified knowledge areas beyond Buddhism that Buddhist chaplains need. Cross-cultural psychology was primary: "American thoughts and Asian thoughts, Western and Eastern, really have huge differences" (L 37:30–38:00). She observed that Asian patients often want suggestions, while Western patients want to express emotions—differences that clinical training must address.

Knowledge of other religions was also essential. Lynn's study of comparative religion and friendships with Catholic nuns equipped her to work across traditions (L 39:30–40:00). Mona noted that Buddhist chaplains must learn to pray in the language of other traditions and participate in Jewish and Christian rituals (M 24:37–26:01).

These knowledge requirements suggest that Buddhist chaplaincy training cannot be solely Buddhist. It must include substantial content about other traditions and about cultural differences in how patients experience and express spiritual need.

The Question of Post-Discharge Care

Wynn raised a structural limitation of hospital chaplaincy that training programs might address: care ends at discharge. For patients who become genuinely interested in Buddhism through chaplain visits, there is no way to continue the connection: "After they leave, they check out, we have no way to connect with them, like we cut off our connection. That is a pity" (W 39:45–40:30).

This contrasts with counseling, where appointments can continue, and with temple-based practice, where ongoing relationships are possible. Wynn's question—"How can we provide the service for them after they check out?"—points toward a more comprehensive model of spiritual care that bridges hospital and community.

Realistic Guidance for Monastics

Lynn offered practical advice for monastics entering CPE: adjust expectations about respect, know how monastic habits may be perceived by peers, and recognize that what brings joy to monastics may differ from what brings happiness to others (L 52:30–

56:00). Her guidance acknowledged the challenges while affirming the profound rewards of chaplaincy work.

Summary: The Shared Experiential Landscape

The cross-case analysis reveals both common structures and individual differences in the lived experience of Buddhist monastics engaging in CPE. Although the participants were from different traditions, cultural backgrounds, and clinical settings, common core challenges were identified by participants: negotiating dual identities; transforming emotional awareness; applying Buddhist concepts in clinical contexts; navigating cultural and religious differences; contributing unique gifts; and envisioning training for future Buddhist chaplains.

The negotiation of dual identities was common in many ways. Some participants achieved seamless integration, others developed clear role differentiation, and most navigated a continuous process of adjustment. The "fundamental puzzle" Lynn named—how to be both a good monastic and a good chaplain—had no single resolution but required ongoing attention.

The transformation of emotional awareness was equally widespread. Participants discovered suppressed feelings, learned to stay with patients' emotions, and questioned whether monastic training might sometimes produce emotional numbness rather than genuine equanimity. This transformation was not a rejection of monastic formation but its deepening—an integration of emotional availability with meditative stability.

The application of Buddhist concepts required careful discernment. Participants drew on compassion, impermanence, and the Four Noble Truths but learned to present them in ways that patients could receive. Traditional vocabulary was generally avoided;

meditation became a primary vehicle for sharing Buddhist wisdom. The "why" question presented a distinctive challenge, as Buddhist explanations for suffering were available but could only be offered when patients explicitly sought them.

Cultural and religious differences shaped every participant's experience. For non-native speakers, language was a constant challenge. For Asian monastics, visible differences triggered assumptions and, in some cases, specific religious bias. However, differences also served as a learning opportunity, as exposure to interfaith encounters broadened people's perspectives.

Buddhist monastics' unique contributions included the energy of compassion that patients could feel, meditation resources that could be adapted to clinical needs, and the surprise of an open-minded tradition that challenged assumptions about religious figures. Their service was to all patients, based on the bodhisattva vow to serve all beings.

Some believed that separate programs for Buddhist chaplaincy training should be created; others disagreed. Some argued that interfaith training was essential to serving diverse populations; others argued that collective Buddhist organizing was critical to transforming existing structures. These positions may be more complementary than contradictory and point to a future in which Buddhists are more present and influential in chaplaincy and retain their interfaith commitment.

Across all these themes, participants demonstrated a remarkable self-awareness, honesty about struggles, and commitment to growth. Their narratives reveal CPE as a transformative experience that challenges and deepens monastic formation, equipping participants to serve suffering others with compassion, skill, and presence. The "gem" of Buddhist wisdom, as Wynn named it, is offered not as doctrine to be imposed but as

presence to be shared—a gift that, when received, can support patients in their most vulnerable moments.

To support clarity and traceability, Tables 3 through 9 have been summarized, consolidating each participant's personal experiential themes that were previously elaborated in the idiographic analysis. Presented side-by-side in tabular form, these summaries allow the reader to quickly grasp each monastic's distinctive concerns, turning points, and interpretive frames and to see how the personal and contextual conditions of CPE (e.g., hospital culture, supervision, interfaith encounter, institutional expectations, and patient suffering) were lived and made meaningful by each individual.

The cross-case thematic framework is presented in Table 10 below. This framework emerged from an iterative analytic process, evolving from within-case understanding to across-case synthesis. This table organizes the findings into six superordinate themes and their subordinate themes, while also indicating which participants contributed to each theme. In keeping with IPA, this structure does not claim uniformity; rather, it highlights family resemblances across cases, recurring experiential patterns that became intelligible through comparison, while acknowledging that certain themes were more central for some monastics than for others. The cross-case themes are grounded in participants' accounts and phrasing, yet they also reflect the interpretive work of the researcher in identifying underlying meanings, tensions, and developmental trajectories embedded in the participants' narratives.

Table 10: Cross-Case Themes with Participant Contributions

Superordinate Theme	Subordinate Theme	Contributing Participants
1. The Negotiation of Dual Identities	The Fundamental Puzzle of Two Roles	John, Dora, Hope, Faye, Lynn, Wynn, Mona

Superordinate Theme	Subordinate Theme	Contributing Participants
	The Boundary Problem	Dora, Hope, Lynn, Wynn, Mona
	Hierarchical vs. Egalitarian Models	Lynn, Mona
	Divergent Resolutions	John, Lynn, Mona
2. The Transformation of Emotional Awareness	The Discovery of Tears	Lynn
	The Discovery of the Wall	Dora
	The Question of "No Feeling"	Lynn
	Cultural Dimensions of Emotional Expression	Dora, Lynn
3. The Application and Adaptation of Buddhist Concepts	Core Concepts in Clinical Practice	John, Dora, Hope, Faye, Lynn, Wynn, Mona
	The Challenge of Buddhist Language	John, Dora, Hope, Faye, Lynn
	Meditation as Clinical Tool	Dora, Hope, Faye, Lynn, Wynn
	The "Why" Question and Buddhist Resources	John, Lynn, Mona
	The Challenge of Application	Faye
4. The Navigation of Cultural and Religious Difference	The Experience of Being an Outsider	Dora, Faye, John
	Linguistic and Cultural Barriers	Dora, Faye, Mona
	The Challenge of Asian Patients	Dora, Faye, Lynn
	Specific Religious-Cultural Bias	Mona
	Learning from Difference	Wynn, Mona
5. The Distinctive Contributions of Buddhist Monastics to Chaplaincy	The Energy of Compassion	John, Lynn, Mona
	Meditation Resources for Clinical Settings	Dora, Hope, Lynn, Wynn
	The Surprise of Open-Minded Tradition	Hope
	Serving Beyond Buddhism	Lynn
6. The Vision for Buddhist Chaplaincy Training	Essential Buddhist Frameworks	Dora, Hope, Faye, Lynn, Wynn, Mona
	The Debate Over Sectarian Training	Hope, Mona
	The Need for Additional Knowledge	Lynn, Mona

Superordinate Theme	Subordinate Theme	Contributing Participants
	The Question of Post-Discharge Care	Wynn
	Realistic Guidance for Monastics	Lynn

Following the previous table, Table 11 below provides an at-a-glance view of how themes are distributed across the seven participants. This distributional summary is not intended to function as a quantitative measure of prevalence or importance. Instead, it serves as an interpretive map of convergence and variation: it helps the reader see where a theme appears broadly across multiple cases (suggesting a shared dimension of monastic experience in CPE) and where a theme appears more selectively (suggesting a distinctive inflection shaped by lineage, role expectations, cultural location, prior formation, institutional context, or the participant's particular CPE site and supervisory relationship).

Table 11: Summary of Thematic Distribution

Participant	Superordinate Themes Most Salient	Unique Contributions
John	1, 3, 5	Seamless integration; teacher validation; hospice focus
Dora	1, 2, 3, 4	Emotional wall; robe as skin; cultural emotional conditioning
Hope	1, 3, 4, 5, 6	Multifaith model; critical consciousness; systemic critique
Faye	1, 3, 4, 5, 6	Struggle for integration; compassion rebalancing; Phantom City insight
Lynn	1, 2, 3, 4, 5, 6	Middle path; emotional transformation; clinical meditation expertise; research; cross-cultural psychology
Wynn	1, 3, 4, 5, 6	Honest questioning about impact; post-discharge care; transcendent identity
Mona	1, 2, 3, 4, 5, 6	Functional role differentiation; Korean Christian bias; interfaith training emphasis

The themes are grounded in participants' accounts while representing the researcher's engagement with the data. The distribution of themes across participants reflects both convergent patterns and the unique contributions each individual brought to understanding this phenomenon.

The three types of tabular components presented herein include: (1) idiographic thematic summaries (Tables 3–9), (2) the synthesized cross-case thematic framework (Table 10), and (3) thematic distribution analysis (Table 11). Together, these elements establish a coherent link between the in-depth individual narratives and the overarching interpretive findings of this study. They prepare the reader for the subsequent discussion of how Buddhist monastic identity, contemplative formation, and clinical pastoral practice meet within the U.S. CPE environment and how participants navigated the promises and pressures of becoming legible as spiritual care providers in predominantly Western, interprofessional, and often implicitly Christian institutional settings.

Mapping Findings to the Research Questions

This study sought to explore the lived experience of Buddhist monastics participating in CPE, guided by three research questions that informed every stage of the inquiry. These can be presented as one central research question and two sub-questions:

Central question: How do Buddhist monastics experience and make meaning of their participation in CPE? This is the broad, phenomenological question.

Sub-question 1: How do Buddhist monastics negotiate their dual roles as Buddhist renunciates and clinical spiritual caregivers within healthcare institutional contexts? This

question gets at identity work—the tension between being a monastic and being a chaplain.

Sub-question 2: How do Buddhist monastics draw on Buddhist teachings and practices in clinical encounters and reflective learning within CPE? This question concerns application and translation—how the Dharma actually shows up in their clinical practice.

Through interpretative phenomenological analysis of seven participants' narratives—John, Dora, Hope, Faye, Lynn, Wynn, and Mona—this study has illuminated the complex, multifaceted nature of Buddhist monastic engagement with CPE. This section synthesizes the findings in relation to each research question and presents a summary table of key findings. For ease of reference, these three research questions are hereinafter referred to as RQ1, RQ2, and RQ3.

RQ1: Experiencing and Making Meaning of CPE

The Experiential Arc: From Challenge to Transformation

All seven participants described CPE as a deeply challenging but ultimately transformative experience. Participants derived meaning from this experience, which clustered around several core dimensions.

Initial Disorientation and Challenge. For most participants, CPE began with significant disorientation. Dora described herself as "a nervous person" who found the hospital environment intimidating (D 6:13–6:30). Faye characterized her summer CPE as "very, very, very intense and very, very, very intimidating" (F 5:37–6:00). Wynn said, "At the beginning, it is very hard to get the connection with the people who reject you to

talk" (W 7:48–8:10). Language barriers compounded this initial challenge for non-native speakers, while all participants faced the unfamiliarity of the clinical environment.

The Crucible of Patient Encounters. Participants made meaning through direct encounters with suffering. John worked with dying children and their families, describing it as "a very profound and moving experience" (J 3:18–4:44). Lynn's work with dying patients in palliative care and the emergency department exposed her to suffering in its most acute forms (L 13:00–14:00). Faye's painful visit to a woman in unrelieved pain became a catalyst for learning (F 13:30–15:30). These encounters were not merely clinical experiences; they were existential confrontations with the realities of illness, death, and human vulnerability.

Peer and Supervisor Relationships as Containers. Participants' relationships with supervisors and peers profoundly shaped their understanding of CPE. John maintained contact with cohort members "all over the world, literally," through Zoom and WhatsApp (J 6:50–7:05). Dora's supervisor "push[ing] me very hard" in directions she didn't expect, pointing out things she didn't know about herself (D 7:00–7:30). Her peers corroborated Faye's feeling of being an outsider by creating moments of connection. Mona relied on peers to help her understand patients and shared Buddhist chanting in return (M 6:30–8:00). These relationships provided the container within which difficult learning could occur.

Self-Discovery and Emotional Awakening. A central dimension of meaning-making was the discovery of previously unrecognized aspects of self. Lynn's recovery of tears after ten years without crying represented a profound transformation (L 19:00–21:00). Dora's discovery of her emotional "wall" enabled her to begin lowering it (D

8:30–9:50). Mona's integration of theoretical compassion with clinical practice gave her new understanding of her own capacities (M 16:21–17:30). For these participants, CPE became a vehicle for self-knowledge that monastic training alone had not provided.

Testing and Validating Buddhist Learning. Several participants framed CPE as a test or validation of their Buddhist formation. Lynn explicitly sought to test whether she really understood the suffering she taught about: "Do I really understand the sufferings? So I want to test myself" (L 3:00–3:30). John found that "what CPE allowed me to do was validate the kinds of things that I believe as a Buddhist" (J 8:28–8:43). This testing function gave CPE meaning as a field where theoretical knowledge could become embodied wisdom.

Vocational Clarification. For some participants, CPE clarified or confirmed vocational direction. John had already chosen chaplaincy before CPE, but the training deepened his commitment (J 0:48–2:22). Mona discovered through CPE that chaplaincy was "a good match" despite her initial instrumental motivation (M 1:49–2:00). Hope's CPE experience, combined with her therapy training, clarified her vision for serving the Buddhist community (H 41:35–42:30). For others, like Faye, the vocational implications continued to unfold after the program ended.

Meaning-Making Frameworks

Participants drew on multiple frameworks to make meaning of their CPE experience.

Buddhist Frameworks. Participants explicitly interpreted their CPE experience through Buddhist lenses. John framed chaplaincy as "living the Dharma" (J 1:48–2:04). Lynn saw it as practicing bodhisattva vows (L 49:30–50:30). Faye came to understand

her role through the Lotus Sutra's Phantom City parable (F 32:30–36:00). Dora applied the three tenets of Zen Peacemakers (D 28:07–28:50). These frameworks provided interpretive resources for understanding what they were doing and why it mattered.

Therapeutic Frameworks. Participants with prior therapeutic training drew on those frameworks as well. Hope's MFT background gave her clinical confidence and a comparative perspective (H 0:15–0:52, 5:45–6:30). Lynn's psychology major and cognitive-behavioral therapy training informed her work with patients (L 38:00–39:00). Mona's MA in Buddhist Counseling Psychology provided the foundation for her CPE learning (M 0:00–1:00). These therapeutic frameworks were complementary to the Buddhist frameworks, providing additional interpretive resources.

Critical Frameworks. Hope uniquely developed a critical framework for understanding her CPE experience, analyzing power dynamics and calling for collective Buddhist action (H 34:08–41:18). This political meaning-making was distinctive to his narrative.

Summary: The Meaning of CPE for Buddhist Monastics

The seven participants in this study experienced CPE as a challenging, often disorienting journey that led to significant transformation. The meaning they derived from this experience encompassed self-discovery, emotional awakening, validation of Buddhist learning, vocational clarification, and, for some, critical consciousness about the structures of chaplaincy itself. Despite the difficulties—language barriers, cultural differences, and feelings of otherness—all seven ultimately found the experience valuable, with several describing it as life-changing.

RQ2: Negotiating Dual Roles

The Universality of Role Negotiation

Every participant in this study engaged in negotiating between their monastic identity and their chaplain identity. This negotiation was not optional but inherent to the experience of Buddhist monastics in CPE. The professional expectations of chaplaincy—boundaries, non-directiveness, interfaith service, and scheduled availability—differed sufficiently from traditional monastic-lay relationships that some form of integration or differentiation was required.

Strategies of Negotiation

Participants employed diverse strategies for negotiating dual roles, which can be understood along a spectrum from integration to differentiation.

Seamless Integration. John experienced no conflict between his roles, reporting "absolutely none" (J 13:01). This integration was enabled by his teachers' affirmation that chaplaincy was "living the Dharma" (J 1:48–2:04). With foundational validation from his tradition, John could experience his clinical work as continuous with rather than separate from his monastic identity.

The Middle Path. Lynn described her negotiation as an ongoing quest for balance—a "middle path" requiring continuous adjustment (L 14:00–14:45). She learned to set boundaries, to shift between roles based on context, and to hold both identities in dynamic tension. Her resolution was not achieved once but continually renegotiated.

Functional Differentiation. Mona developed a clear cognitive distinction between the two roles: "Now I clearly distinguish that the CPE chaplain and monastic are

totally different, really different" (M 11:08–11:45). This clarity allowed her to deploy the appropriate role based on patient need—a monastic with Buddhist patients who sought advice and a chaplain with others who expected listening without direction.

Contextual Identity. Faye adopted an explicitly contextual approach: "I think I'm a Buddhist only when I visit Chinese or Buddhist patients. Or when people are accepting, they're curious and then are open to it… Otherwise, I am just an interfaith chaplain, or I'm a humanist, or an atheist" (F 27:32–28:30). Her identity shifted with context while core commitments remained constant.

Transcendent Identity. Wynn's assertion that "no matter what I change, I'm still monastic" (W 7:47–8:00) reflected her belief that identity transcends external markers. This perspective allows her to comply with institutional requirements while preserving an authentic sense of self—an identity that external changes could not touch.

Institutionally Supported Identity. Cedars-Sinai's multifaith model informed Hope's negotiations, allowing her to wear full robes and uphold her monastic identity without compromise (H 10:10–10:20). Institutional support reduced the need for internal negotiation.

Embodied Negotiation. Dora's negotiation focused on the robe, which she referred to as "my skin" (D 21:02). Her struggle with her supervisor over attire, and her eventual experimentation with secular clothes, represented an embodied process of discovering that identity could survive the modification of external appearance.

Key Sites of Negotiation

Several specific sites of negotiation emerged across participants.

The Robe. The monastic robe was the most visible site of identity negotiation. Dora's struggle (D 19:10–24:13), Wynn's compromise (W 6:27–7:47), Hope's freedom (H 10:10–10:20), and Mona's visibility as an obstacle (M 13:21–14:39) all centered on this physical marker of identity. The robe made monastic identity visible, triggering both positive and negative patient responses and requiring institutional accommodation.

Professional Boundaries. Lynn, in particular, saw the need to establish and maintain professional boundaries as a significant site of negotiation. Her inherent monastic tendency to give away freely, to buy reading glasses, to cook for students, and to offer money was in tension with professional norms (L 9:50–12:30). It took years of practice to learn to set boundaries without losing compassion.

Hierarchical vs. Egalitarian Relationships. The shift from hierarchical monastic-lay relationships to egalitarian chaplain-patient relationships demanded a major reorientation. Mona's contrast between the "control, control, control" approach of an untrained monastic and her own listening approach illustrated this shift (M 21:53–23:30). Lynn described learning to be "a little bit lower" rather than higher (L 23:30–24:33).

Emotional Availability. The negotiation of emotional expression was particularly salient for Lynn and Dora. Lynn's recovery of tears after ten years without crying (L 19:00–21:00) and Dora's discovery of her emotional "wall" (D 8:30–9:50) represented fundamental shifts in their emotional availability—changes that had implications for both their monastic and chaplain identities.

Availability and Time. The monastic model of unlimited availability (24/7, 365 days a year) conflicted with the professional model of scheduled presence. Lynn described the struggle of wanting to stay with a crying patient but having to leave (L

15:30–16:30). This required learning that boundaries were not barriers to compassion but structures enabling sustainable service.

Factors Shaping Negotiation

Several factors influenced how participants negotiated dual roles.

Teacher Support. John's teachers' affirmation of chaplaincy as "living the Dharma" fundamentally shaped his experience of integration (J 1:48–2:04). Dora consulted her senior temple member before experimenting with secular clothes (D 21:30–22:00). The presence or absence of support from one's tradition significantly influenced the negotiation.

Institutional Context. Hope's placement in a multifaith program that encouraged full robes supported his identity (H 10:10–10:20). Wynn's supervisor's rejection of Chinese robes but acceptance of Japanese robes revealed how institutional policies, however arbitrary, shaped the negotiation (W 6:27–7:47).

Cultural Background. Dora's Chinese cultural conditioning around emotional expression shaped her initial relationship to emotion (D 39:36–40:10). Mona's experience of Korean Christian bias further complicated her identity negotiation (M 15:06–15:54).

Prior Experience. John's decades of experience in healthcare and Hope's therapy training provided the foundation for their negotiation approach. Lynn's extensive cross-cultural monastic training gave her the resources to navigate multiple identities.

Individual Temperament. Mona's preference for clear cognitive distinction, Lynn's comfort with dynamic adjustment, and Faye's contextual flexibility—these individual differences shaped the strategies participants developed.

Summary: Negotiation as Core Experience

The negotiation of dual roles was not peripheral but central to the lived experience of Buddhist monastics in CPE. Every participant engaged this negotiation, though their strategies and resolutions varied. The diversity of resolutions—integration, middle path, differentiation, contextual identity, and transcendent identity—suggests that there is no single "correct" way to hold these roles. What matters is that participants engaged the question authentically and arrived at resolutions that allowed them to function effectively while maintaining integrity.

RQ3: Drawing on Buddhist Teachings and Practices

Core Teachings in Clinical Practice

Participants drew on a range of Buddhist teachings in their clinical work, though almost always in adapted forms.

Compassion (*karuṇā*). Compassion was universally named as the primary Buddhist resource. John identified "wisdom and compassion" as foundational (J 13:01–13:48). Lynn described patients perceiving "positive energy" from her compassionate presence (L 31:00–32:00). Mona learned to "compassionately listen" through CPE (M 16:21–17:30). Compassion was not merely a concept but an embodied quality that patients could sense.

Impermanence (*anicca*). Impermanence was widely cited, though with caution about direct discussion. John named it a core concept (J 16:35–17:10). Hope taught patients to observe pain "just like a wave" (H 17:10–18:00). Faye struggled to apply it initially but later found connections through the Lotus Sutra (F 32:30–36:00). Lynn

learned from a supervisor's story not to tell grieving people "life is impermanent" (L 1:32–2:30).

The Four Noble Truths. This framework informed several participants' clinical understanding. Dora applied it to recognize suffering in every room and consider how to reduce it (D 30:10–31:20). Lynn noted that understanding suffering and its causes supported clinical work, though the goal was not to make patients happy but to be with them (L 20:30–21:00). Hope used the framework implicitly in her approach to patients' pain (H 16:35–18:00).

The Eightfold Path. Wynn identified Right View as particularly clinically relevant—helping patients regain perspective and hope when lost in despair (W 31:58–33:00). Lynn observed that the path offered tools for patient interaction, but skillful delivery was essential (L 34:30–36:00).

The Three Tenets of Zen Peacemakers. Dora explicitly applied Not Knowing, Bearing Witness, and Loving Actions as her clinical framework (D 28:07–28:50). These tenets provided structure for approaching patients without imposing Buddhist vocabulary.

Bodhicitta and Bodhisattva Vows. Lynn framed her chaplaincy work as a practice of bodhisattva vows—serving all beings, including non-Buddhists (L 39:30–40:00, 49:30–50:30). This framing gave her work meaning within her Buddhist commitments.

The Challenge of Buddhist Language

A consistent finding across participants was the inappropriateness of using traditional Buddhist vocabulary with most patients. John noted that one cannot tell a mother with a dying child about karma (J 15:59–16:48). Faye stated directly that terms

like “suffering,” “emptiness,” and “impermanence” are “too big, too hollow”—too abstract for patients in crisis (F 39:06–39:30). Lynn developed a clear principle: “I do not talk about these terms with my patient unless they request” (L 1:32–2:30). Hope adapted her language, asking “What is the issue that you’re facing?” rather than speaking of suffering (H 22:53–23:20). Dora found that her peers could not understand her Buddhist concepts (D 29:00–29:50).

This challenge was not merely linguistic but existential. Patients in acute suffering do not need philosophical teaching; they need presence, support, and someone to bear witness. The “big words” of Buddhist philosophy, however profound, are not advantageous in the midst of crisis.

Meditation as Primary Clinical Tool

Meditation emerged as the primary vehicle for sharing Buddhist wisdom in clinical settings. All participants who discussed clinical practice mentioned leading meditation with patients.

Individualized Teaching. Lynn offered the most developed account of clinical meditation, teaching differently to each patient based on “their medical situations, their personalities, and their living environments” (L 42:00–42:30). For patients in pain, she used body scans adapted to specific locations and patient temperaments. For those on the deathbed who could not feel their bodies, she improvised meditation on the bed itself (L 46:30–47:00).

Group Facilitation. Wynn guided both individual patients and family groups in meditation (W 23:24–24:29). Dora facilitated groups in the hospital using skills learned in the Way of Council training (D 3:30–4:37).

Adaptation Without Buddhist Terms. Hope used visualization and breathing techniques, often without referring to them as meditation, in order to adapt to the comfort levels of patients (H 32:20–32:43). This flexibility allowed patients to receive the benefits of meditation without resistance to Buddhist terminology.

The Importance of Personal Practice. Lynn emphasized that effective clinical meditation teaching requires personal practice: "If you have never practiced meditation, that is totally different. Even though you are a native speaker, English is much better than mine. But my leading and your leading, the result is different" (L 41:30–42:00). The teacher's own practice matters; meditation cannot be reduced to words.

Addressing the "Why" Question

Several participants addressed the challenge of patients' "why" questions—why my child is dying, why bad things happen to good people. Lynn observed that CPE training teaches chaplains to respond, "I really don't have answers for you" (L 31:00–31:30). Yet "as a monastic, I can tell them why—why this happened. I can tell them, right? I can open the Buddhist scriptures" (L 31:30–32:00).

This created an ongoing tension. Buddhism offers explanations through karma, causes and conditions, and the nature of existence. Yet clinical training prohibits offering such explanations unless explicitly requested. In practice, participants developed discernment. Mona distinguished among patients: those who believe they will "go to Jesus" have no interest; those who are non-religious, Buddhist, or spiritual may be open (M 18:13–19:30). Lynn noted that Asian patients often want suggestions while Westerners want to express emotions (L 32:30–33:00).

Reflective Learning: Integrating Teachings with Experience

The integration of Buddhist teachings with clinical experience was not automatic but required reflective learning.

The Struggle for Integration. Faye's narrative captured this struggle most vividly. She found the requirement to provide Dharma reflection on clinical encounters puzzling and frustrating: "I struggled very, very hard" (F 30:02–30:30). Her breakthrough came later, through reading the Lotus Sutra and discovering the Phantom City parable as a framework for understanding her role (F 32:30–36:00). This suggests that integration may unfold over time rather than being achieved during CPE itself.

Verbatim and Theological Reflection. Participants engaged in structured reflection through verbatim writing and theological/Dharma reflection. Hope noted that in verbatims, "we have to share our Buddhist standpoint" and reflect Buddhist theories in "my story theology" (H 19:00–20:00). This formal reflection was a key site of learning.

Peer Learning. Mona learned from peers who helped her understand patients and their cultural contexts (M 6:30–8:00). Dora's peers, by their emotional expressiveness, helped her discover her own emotional guardedness (D 8:30–9:50). Peer relationships provided informal reflective spaces.

Supervisory Feedback. Lynn's supervisors challenged her emotional absence, leading to recovery from tears (L 19:00–21:00). Dora's supervisor pushed her in directions she didn't expect, pointing out things she didn't know about herself (D 7:00–7:30). Supervisory relationships were crucial for reflective learning.

The Question of Impact: Planting Seeds

Several participants reflected on the ultimate impact of their work. Wynn posed the most probing questions: "I just feel that what we did, what we do, and what we try—is that very helpful or not?" (W 35:54–36:30). She used the metaphor of Buddhism as a "gem" that patients may not have energy to receive, and the seed metaphor: "Of course, we can't say, 'Oh, we spread our seeds—Buddhist seeds in the society.' That's also okay. But actually, it's very hard. Long way to go" (W 34:30–35:00).

Lynn offered a more developed response to this question. She acknowledged that patients may not achieve liberation in this lifetime but argued that her work plants "good seeds" in their consciousness. Even if they do not achieve ultimate freedom, they may enjoy a better rebirth, a better life, and greater spiritual capacity in the future. (L 53:30–54:30). This defense drew on Buddhist psychology: seeds planted through meditation and compassion remain in the storehouse consciousness (*ālaya*) and bear fruit in future lives.

Summary: Skillful Means in Clinical Context

Participants drew on Buddhist teachings and practices in ways that can be understood as skillful means (*upāya*), adapting the Dharma to the capacities and needs of those they served. They avoided using traditional vocabulary with patients who might not understand it. They provided meditation in forms patients could participate in. They selectively shared teachings when patients were ready. They planted seeds without knowing when, or whether, they would grow. This adaptive, patient-centered approach represents a sophisticated integration of Buddhist wisdom and clinical sensitivity.

Summary of Key Findings by Research Question

Following the detailed narrative analysis of each research question, Table 12 offers a consolidated summary of the key findings across the three guiding inquiries of this study. Based on the interpretative phenomenological analysis of seven Buddhist monastics' lived experiences in CPE programs in the United States, the table distills the essential themes and representative participant contributions for RQ1, RQ2, and RQ3.

Table 12: Summary Table of Key Findings by Research Question

Research Question	Core Findings	Key Participant Contributions
RQ1: Experiencing and Making Meaning of CPE	CPE is experienced as challenging, often disorienting, yet transformative. Meaning-making occurs through patient encounters, peer and supervisor relationships, self-discovery, validation of Buddhist learning, and vocational clarification.	Lynn: Testing Buddhist learning in a real field (L 3:00–3:30); John: CPE-validated Buddhist beliefs (J 8:28–8:43); Faye: Struggle and gradual integration (F 30:02–36:00); Dora: Discovery of emotional wall (D 8:30–9:50); Mona: From instrumental motivation to appreciation (M 1:49–2:00).
RQ2: Negotiating Dual Roles	All participants negotiate dual identities through diverse strategies: integration, middle path, differentiation, contextual identity, and transcendent identity. Key sites of negotiation include the robe, professional boundaries, hierarchical relationships, emotional availability, and time.	John: Seamless integration through teacher validation (J 1:48–2:04, 13:01); Lynn: Middle path and boundary learning (L 9:50–23:00, 14:00–14:45); Mona: Functional differentiation (M 11:08–11:45); Dora: Robe as skin (D 19:10–24:13); Wynn: Transcendent identity (W 7:47–8:00); Hope: Institutionally supported identity (H 10:10–10:20).
RQ3: Drawing on Buddhist Teachings and Practices	Participants draw on compassion, impermanence, the Four Noble Truths, the Eightfold Path, and bodhisattva ideals, but almost never use traditional vocabulary with patients. Meditation is the primary clinical tool, taught in highly individualized ways. The "why" question presents distinctive challenges. Reflective learning takes place through verbatim, peer interaction, and supervision.	Lynn: Individualized meditation teaching (L 42:00–47:00) and the principle of not mentioning terms (L 1:32–2:30); Faye: Phantom City revelation (F 32:30–36:00), critique of wisdom-compassion imbalance (F 31:30–33:30); Dora: Three Tenets framework (D 28:07–28:50); Wynn: Right View (W 31:58–33:00), questioning of impact (W 35:54–37:00); Mona: Selective teaching based on readiness (M 18:13–19:30).

As shown above, RQ1 captures the challenging, often disorienting, but ultimately transformative aspects of CPE, where meaning-making takes place through patient encounters, peer and supervisor relationships, self-discovery, and vocational clarification. RQ2 describes the spectrum of participants' negotiations of their dual identities as Buddhist monastics and CPE trainees, from integration and "middle path" approaches to contextual and transcendent identity narratives. RQ3 outlines how participants employ Buddhist teachings and practices (e.g., compassion, impermanence, meditation) in clinical settings, while infrequently using traditional Buddhist terminology with patients. Rather, they are working on personalized approaches and reflective learning tools such as verbatims and supervision.

The summary table enables the reader to quickly obtain an overview of the key patterns identified in the analysis before the chapter proceeds to further discussion or conclusions.

Chapter Five:

Discussion

Synthesis and Interpretation of Findings

This research sought to explore the lived experience of Buddhist monastics engaged in CPE in the United States. Through detailed examination of the narratives of seven participants—John, Dora, Hope, Faye, Lynn, Wynn, and Mona—the study has illuminated the complex, multifaceted nature of Buddhist monastic engagement with a training model historically shaped by Christian pastoral traditions. The findings suggest that for these participants, CPE is far more than merely a professional credentialing pathway; it is an experiential journey marked by a transformative encounter that challenges, deepens, and sometimes fundamentally reconfigures their understanding of both monastic identity and compassionate service.

From the analysis, six superordinate themes emerged: the negotiation of dual identities, the transformation of emotional awareness, the application and adaptation of Buddhist concepts in clinical contexts, the navigation of cultural and religious difference, the distinctive contributions of Buddhist monastics to chaplaincy, and the vision for Buddhist chaplaincy training. These themes portray a population deeply engaged in meaning-making at the intersection of two worlds. What unites these diverse narratives is the shared experience of what Lynn named the "fundamental puzzle": how to be both a good monastic and a good chaplain, how to hold renunciate commitments and professional responsibilities in creative tension, and how to offer Buddhist wisdom in forms that patients of all traditions can receive.

The findings suggest that Buddhist monastics bring distinctive resources to clinical settings—decades of meditation practice, ethical discipline grounded in precepts, familiarity with suffering and impermanence as lived realities rather than abstract concepts, and a quality of compassionate presence that patients can perceive as "positive energy" (Lynn). Yet these same resources can become obstacles when they conflict with clinical expectations: the monastic inclination toward unlimited availability clashes with professional boundaries; the training toward emotional equanimity may mask emotional disconnection; the rich explanatory frameworks of karma and rebirth must be withheld unless explicitly requested.

Perhaps most significantly, the findings reveal that CPE serves for these participants as a form of what John's teachers called "living the Dharma"—an arena where Buddhist teachings are tested, embodied, and deepened through direct engagement with suffering. Lynn's motivation to "test myself" and discover whether she really understood the suffering she taught about captures this dimension profoundly. For monastics who have spent years or decades in temples and classrooms, the hospital becomes a laboratory where theoretical knowledge meets lived reality, where the Four Noble Truths are not doctrines to be recited but phenomena to be encountered in every patient room.

Discussion in Relation to the Research Questions

Having presented the detailed findings in Chapter 4, including the systematic mapping of themes to each research question, this section moves beyond descriptive summary to engage in deeper interpretive analysis. Rather than restating what

participants reported, I examine the underlying dynamics, tensions, and implications that emerge when the findings are considered collectively and in relation to broader questions about Buddhist monastic identity, clinical formation, and the future of interfaith spiritual care.

RQ1: Experiencing and Making Meaning of CPE

The first research question asked how Buddhist monastics experience and make meaning of their participation in CPE. While Chapter 4 documented the thematic content of this meaning-making—self-discovery, emotional awakening, and validation of Buddhist learning—several more profound questions emerge when these findings are considered interpretively.

The Paradox of Formation Through Disorientation

A striking pattern across participants was that meaning-making arose not despite disorientation but through it. Faye's experience of being "thrown" into clinical encounters without preparation, Dora's discovery of her emotional "wall" through contrast with expressive peers, and Lynn's recovery of tears after years without crying all suggest that CPE's formative power lies partly in its capacity to disrupt established patterns of being. This raises a fundamental question: What is the relationship between monastic formation and clinical formation, and why does the latter require disruption of the former?

One interpretation is that monastic training, whatever its spiritual profundity, may cultivate certain protective structures—emotional containment, hierarchical relational patterns, and distance from intense affect—that are adaptive in temple life but become

obstacles to the kind of presence required in clinical settings. The "wall" Dora discovered was not a failure of her monastic formation but perhaps its success in a different context. The challenge, then, is not that monastic formation is deficient but that it was designed for a different environment. CPE's disruption of these patterns is not a critique of monastic training but an adaptation to a new context.

This suggests a more profound understanding of CPE as a form of re-formation rather than simply formation. Participants in CPE were already formed as monastics, with some having been in this state for decades. What CPE offered was not formation from scratch but re-formation for a new context: learning which aspects of monastic training translate directly to clinical work (compassion, equanimity, and familiarity with suffering); which require adaptation (emotional expression and boundaries); and which may need to be temporarily suspended (hierarchical relating and teaching orientation).

The Hermeneutics of Self-Discovery

The meaning participants made of CPE was fundamentally interpretive: they were engaged in reading their own experience through multiple interpretive lenses. Lynn interpreted her emotional transformation through the lens of monastic practice: "I had processed all that grief already" (L 17:36–18:20) and then through the lens of clinical supervision: "If you do not feel the pain, how can you feel the patient's pain?" (L 19:00–20:00). Faye interpreted her clinical encounters through the lens of the Lotus Sutra, discovering the Phantom City parable as a framework for understanding her role. Dora interpreted her emotional guardedness through the lens of cultural conditioning: "As an Asian, a Chinese Asian, we are not supposed to express our emotions" (D 39:36–40:10).

This interpretive layering—what the IPA terms the "double hermeneutic"—was not merely an analytic process for the researcher but a lived process for the participants. They were already making meaning of their experience before the researcher arrived, drawing on the interpretive resources available: Buddhist teachings, cultural narratives, clinical frameworks, and peer feedback. This suggests that CPE functions for Buddhist monastics not only as skills training but also as an extended exercise in hermeneutical reflection—learning to read oneself, one's tradition, and clinical situations in relationship to one another.

The Question of Vocation

A deeper dimension of meaning-making that emerged across participants was vocational clarification or reorientation. For John, CPE deepened a vocation already chosen and affirmed by his teachers. For Mona, who entered with purely instrumental motivation, CPE revealed that chaplaincy was "a good match"—a discovery that could not have been predicted. For Hope, CPE clarified her vision for serving the Buddhist community through sharing the resources she had accumulated. After the program ended, vocational implications continued to unfold for Faye, indicating that the program itself may not fully convey the meaning of CPE.

This temporal dimension of meaning-making deserves attention. Participants continued to make meaning of their CPE experience months and even years after completion. Faye was still processing her experience at the time of the interview, with new insights emerging regularly. Lynn's understanding of her "fundamental puzzle" had evolved through years of practice. This suggests that the meaning of CPE for Buddhist monastics is not fixed at the time of training but unfolds over time as subsequent

experience provides new contexts for interpretation. Any assessment of CPE's impact that measures only immediate outcomes may miss the longer arc of meaning-making that participants themselves describe.

RQ2: Negotiating Dual Roles

The second research question asked how Buddhist monastics negotiate their dual roles as renunciates and clinical caregivers. While Chapter 4 documented the strategies participants employed—integration, differentiation, and middle path—deeper questions emerge about the nature of the tension being negotiated and what it reveals about both monastic identity and professional chaplaincy.

The Ontology of Role vs. Identity

A fundamental question underlying this negotiation is whether "monastic" and "chaplain" are best understood as roles one performs or as identities one embodies. Participants varied in their implicit answer to this question. Mona's clear distinction between roles suggests she views them as functions she can deploy based on context—the "monastic role" with Buddhist patients, the "chaplain role" with others. Wynn's assertion that "no matter what I change, I'm still monastic" suggests a view of monastic identity as ontological—something that persists regardless of external role performance. Lynn's "middle path" suggests that she experiences both roles as partially constitutive of her identity and in need of ongoing integration work.

This distinction has important practical implications. If "monastic" and "chaplain" are primarily roles, then the challenge lies in learning when to perform each role and how to switch between them smoothly. If they are identities, the challenge is deeper: how to

hold two ways of being in a single self without fragmentation. The diversity of participants' resolutions suggests that both conceptualizations are viable and that individuals may gravitate toward one or the other based on temperament, tradition, and context.

The Hidden Curriculum of Professional Boundaries

The boundary struggles participants described—particularly Lynn's difficulty learning to say no to patient requests, to leave at scheduled times, and to refrain from gift-giving—reveal something important about professional chaplaincy's hidden curriculum.[193] Professional boundaries are not merely neutral guidelines for ethical practice; they embody specific assumptions about the nature of helping relationships that may differ from assumptions embedded in monastic-lay relationships.

The monastic model, as Lynn described it, is one of unlimited availability: "We work 24 hours, 365 days, right? Anytime, anytime" (L 15:30–16:30). This model assumes that availability to those who seek help is an expression of compassion and that boundaries, if they exist, are permeable and flexible. The professional model, by contrast, assumes that boundaries are essential for a sustainable practice and that being available all the time can lead to burnout and compromised care.

The conflict between these models is not simply a disagreement about technique but a deeper difference in how compassion is understood and enacted. For Lynn, learning to set boundaries felt like learning to be less compassionate—until she experienced the alternative and discovered that boundaries could enable, rather than limit, sustainable

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[193] Jonathan Pye, "Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No," *Implicit Religion* 11, no. 2 (2008): 193–94, https://doi.org/10.1558/imre.v11i2.193.

presence. This suggests that the professional boundary model may need to be not merely taught but translated for monastics whose formation has embedded a different understanding of compassionate availability.

The Politics of Visibility

The negotiation over monastic attire—Dora's robe as "skin," Wynn's compromise with Japanese robes, and Hope's freedom to wear full robes—reveals a political dimension of identity negotiation that deserves attention. The robe makes monastic identity visible, and visibility carries both risks and opportunities.

Visible differences can provoke rejection, as Mona experienced with Korean Christian patients and as several other participants did with patients who assumed they were present to proselytize. It can also trigger curiosity and connection, as Hope described when patients asked about her tradition and discovered unexpected openness. The politics of visibility thus involve navigating a double-edged reality: being seen means being vulnerable to prejudice but also accessible to those who might benefit from what one offers.

Institutions' policies about religious attire are not neutral. Wynn's experience of Japanese robes being acceptable while Chinese robes were not reveals that such policies may reflect cultural familiarity rather than any consistent principle. The message is, explicit or implicit, that some forms of religious expression are welcome while others need to be modified. This raises the question of whether institutions are genuinely committed to religious diversity or merely tolerant of difference within familiar bounds.

RQ3: Drawing on Buddhist Teachings and Practices

The third research question asked how Buddhist monastics draw on Buddhist teachings and practices in clinical encounters and reflective learning. Chapter 4 explained how participants adapted specific teachings, but deeper questions remain about the nature of these adaptations and their implications for tradition and context.

The Problem of Translation Without Betrayal

The consistent finding that participants avoided traditional Buddhist vocabulary with patients raises a fundamental question: When does translation become betrayal? At what point does adapting the Dharma for clinical contexts risk losing what is essential?

Participants navigated this tension through a distinction between terms and content. Lynn articulated this distinction most clearly: "I usually do not use the Buddhist terms. I use the content" (L 34:30–35:00). The content—compassion, presence, acceptance, and the invitation to observe experience without judgment—could be offered without the terms that might trigger resistance or confusion. This suggests a model of translation that preserves essence while adapting form.

However, this model raises its own set of questions. Is the essence of Buddhist practice separable from the terms in which it has been traditionally expressed? Can compassion be offered as a generic human quality without reference to its Buddhist framing, or does something become lost when the framing is absent? Participants seemed to answer that the framing could be withheld without loss—indeed, that withholding it was sometimes necessary for patients to receive what was offered. This suggests a pragmatic rather than purist approach to tradition: the goal is not to preserve Buddhist

purity but to serve suffering beings, and if serving requires adaptation, adaptation is justified.

The Karmic Question

The challenge of addressing patients' "why" questions revealed a distinctive tension in Buddhist chaplaincy. Buddhism offers explanations for suffering—through karma, causes and conditions, and the nature of existence—that are more elaborate than the "God's will" explanations available in some theistic traditions. Yet clinical training teaches chaplains not to offer such explanations unless explicitly requested.

This creates a paradoxical situation: having more explanatory resources may actually constrain practice more than having fewer, because the prohibition on offering explanations applies regardless of how rich one's explanatory framework is. Lynn observes that Christian chaplains may have "no tools" beyond "God's will," while she possesses a wealth of Buddhist teachings that she cannot use, highlighting this irony.

The more profound question is whether the clinical prohibition on offering explanations is itself culturally specific. The assumption that patients should not be given explanations for suffering may reflect Western therapeutic norms that prioritize emotional exploration over cognitive understanding. In contexts where patients expect and want explanations, as Lynn noted, "most of the Asian patients want to get my suggestions" (L 32:30–33:00), withholding them may be experienced as withholding care. This suggests that the clinical norm against offering explanations may need to be applied with cultural discernment rather than as a universal rule.

Meditation as Embodied Translation

The centrality of meditation in participants' clinical practice offers a clue to how the Dharma can be translated without being betrayed. Meditation is practice rather than a proposition; it does not require assent to doctrines but invites participation in a way of being. When Lynn guides a dying patient in meditating on the shape of their bed, she is not teaching Buddhist philosophy but offering an experience of presence that Buddhist practice has made available to her.

Meditation can then be understood as an embodied translation, a way of communicating the wisdom of Buddhism through experience rather than through language. Patients who would resist or not understand talk about impermanence can be guided to observe the changing nature of their own experience. Those who would reject talk about non-self can be invited to notice the thoughts and sensations that arise and pass away. The teaching is present, but it is offered as an invitation rather than instruction, as experience rather than doctrine.

This model of embodied translation has implications for how Buddhist chaplains are trained. If meditation is the primary vehicle for sharing Buddhist wisdom in clinical contexts, then personal meditation practice must be central to chaplaincy formation. Lynn's insistence that effective clinical meditation requires personal practice—that technique alone is insufficient—underscores this point. The chaplain's own practice becomes the source from which clinical presence flows.

Cross-Cutting Reflections

Beyond the specific questions addressed to each research question, three cross-cutting reflections emerge from considering the findings collectively.

The Question of Effectiveness

Wynn's honest questioning, "I just feel that what we did, what we do, and what we try—is that very helpful or not?" (W 35:54–36:30) deserves serious engagement. If brief hospital encounters plant seeds that may never grow, if patients receive at best a "stone impression" of Buddhism rather than the full "gem," what justifies the investment of time and resources in chaplaincy?

Lynn's response—that seeds planted in consciousness may bear fruit in future lives—offers a Buddhist framework for understanding impact that differs from Western outcome measures. But some patients lack this framework, and the study doesn't determine if chaplaincy helps them in this life.

This study cannot empirically answer the effectiveness question, but it can suggest that different populations and contexts may require a different understanding of effectiveness. For some patients, a single encounter of genuine presence may provide comfort that endures. For others, the seed metaphor may be the most honest available framework. For chaplains themselves, the meaning of the work may not depend on measurable outcomes but on fidelity to the bodhisattva vow to serve all beings, regardless of whether that service produces visible results.

The Question of Belonging

Across participants, the experience of being an outsider—linguistically, culturally, and religiously—was pervasive. Even John, whose cohort included six Buddhists, recognized this as exceptional. This case raises questions about belonging that go beyond individual adaptation.

Do Buddhist monastics belong in CPE as it is currently structured, or do they belong despite it? The difference is significant. Belonging in the structure would mean that CPE programs are designed to accommodate and welcome Buddhist participants. Belonging despite the structure means that Buddhist participants succeed through their own effort, often with limited support and in the face of additional challenges.

Hope's call for collective action to transform CPE programs addresses this question directly. If Buddhist chaplains become numerous and organized enough, they may shift from belonging despite the structure to belonging in it—from accommodation to transformation.

The Question of Tradition

Finally, the findings raise questions about what happens to Buddhist tradition when it enters clinical spaces. Is chaplaincy a context in which Buddhism is preserved, adapted, or diluted? The answer may depend on which aspect of Buddhism one considers.

The ethical core of Buddhism—compassion, non-harming, service to beings—seems preserved and even deepened through clinical engagement. Participants described their chaplaincy work as "living the Dharma," as practicing bodhisattva vows, and as testing whether they really understood the suffering they taught about. In this sense, tradition is not lost but enacted.

Clinical contexts necessarily background the doctrinal and philosophical dimensions of Buddhism, including teachings on emptiness, elaborate cosmologies, and specific formulations of karma and rebirth. They remain available to participants personally and to patients who explicitly seek them, but they are not the currency of daily practice.

The question of whether this constitutes adaptation or dilution cannot be answered abstractly. Faye's metaphor of the wooden bucket offers one framework: Buddhism that makes itself useful will be preserved; Buddhism that remains unused will rot. From this perspective, clinical engagement is not a threat to tradition but its condition for survival. One's view of Buddhism and its relation to suffering determines if this is persuasive.

Engagement with the Literature

The findings of this study both resonate with and extend existing scholarship on Buddhist chaplaincy, CPE, and professional identity formation in spiritual care.

Buddhist Chaplaincy and Supervision

Jitsujo T. Gauthier's recent work on American Buddhist chaplaincy supervision provides a valuable framework for understanding the experiences of participants in this study. She notes that "Buddhist chaplaincy in North America emerges within the historical context of Protestant theism" and that "Buddhist chaplains train in CPE chaplain internship/residency programs… Their supervisors are certified CPE educators, who are most often Christian and know very little about Buddhism, its main traditions, tenets, teachings, and values."[194] This description accurately captures the institutional context within which all seven participants navigated their training.

Gauthier's proposed definition of Buddhist supervision as "an engaged relationship with the refuges of Buddha, Dharma, and Sangha, where both educator and

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[194] Jitsujo T. Gauthier, "American Buddhist Chaplaincy Supervision," in *The Oxford Handbook of American Buddhism*, ed. Ann Gleig and Scott A. Mitchell (New York: Oxford University Press, 2024), 446–61, https://doi.org/10.1093/oxfordhb/9780197539033.013.27.

student together embark on the path to awakening, caring for self and others with an open, flexible heart-mind to understand suffering, compassionate action, and spiritual caregiving"[195] offers a constructive vision that resonates with participants' experiences. Lynn's description of her ongoing quest for balance, her engagement with supervisors who challenged her emotional absence, and her integration of bodhisattva vows with clinical practice exemplifies the kind of supervision Gauthier envisions—though Lynn achieved this integration more through her own reflective work than through supervision explicitly framed in Buddhist terms.

Gauthier also notes that Buddhist chaplains' "inner authority comes from confidence in Dharma and practice of the Threefold Training: (1) ethical virtue (*śīla*), (2) mental concentration (*samādhi*), and (3) wisdom/insight (*prajñā*)."[196] This framework illuminates how participants like Lynn, with her decades of meditation practice, and John, with his teachers' validation, could maintain grounded identity even when navigating institutional contexts not designed for them. Their authority came from within their practice, not from external validation.

Minority Religious Representation in CPE

Recent research on Muslim chaplains in CPE provides illuminating parallels to the experiences of Buddhist monastics in this study. Quadri and colleagues found that Somali Muslim chaplain students faced "challenges of racial and religious discrimination," yet their "representation and linguistic diversity were viewed as positive

[195] Gauthier, "American Buddhist Chaplaincy Supervision," 448.
[196] Gauthier, 449.

attributes."[197] Similarly, participants in this study navigated patient biases (Mona's experience with Korean Christians who viewed Buddhist nuns as objects of pity) and institutional expectations that sometimes conflicted with their religious identities (Dora's struggle over the robe and Wynn's compromise on monastic attire).

The recommendation from Quadri and colleagues to "adjust educational requirements for entry into the field to consider professional equivalencies; engage community chaplains; and collaborate with local communities"[198] resonates with Hope's call for Buddhist chaplains to "band together, create a training program, and exert… be a force in itself to break down these paradigms" (H 34:08–34:30). Both studies point toward the need for structural changes that accommodate diverse religious traditions rather than expecting minority traditions to conform to models developed within Christianity.

Dora's and Faye's experience of being the only representative of one's tradition within a CPE cohort is consistent with research findings on Muslim chaplain students who "described their personal journeys and motivations for pursuing careers in healthcare chaplaincy, their impact on hospitalized patients, and the role of expanding perspectives for those with little prior exposure to Somali Muslim faith leaders."[199] For both Buddhist and Muslim trainees, their presence in CPE programs serves not only their own formation but also educates peers and supervisors about their traditions—an additional burden not carried by trainees from majority traditions.

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[197] Nasreen S. Quadri et al., "Expanding Access through Representation and Inclusion in the Spiritual Care Workforce: An Exploratory Qualitative Examination of Insights from Somali Muslim Chaplains and Their Educators in the USA," *Journal of Religion and Health* 63, no. 6 (2024): 4559–79, https://doi.org/10.1007/s10943-024-02134-0.

[198] Quadri et al., "Expanding Access through Representation," 4559.

[199] Quadri et al., 4559.

Buddhist Principles in Clinical Contexts

Wells and colleagues' recent examination of mindfulness and Buddhist principles in oncology care provides important context for understanding how participants in this study applied Buddhist teachings.[200] They note that "Buddhist philosophy is grounded in the three marks of existence: impermanence (*anicca*), suffering (*dukkha*), and non-self (*anattā*)" and that these "provide the Buddhist foundations for understanding the human condition."[201] This study's participants precisely drew on these foundations, but they did so with careful attention to their application.

Wells and colleagues raise concerns about "the Westernisation and cultural appropriation of Buddhist wisdom" and argue for ensuring "practitioners are knowledgeable about Buddhist philosophy and equipped to communicate the tradition's origins transparently to oncology patients."[202] The participants in this study demonstrate a model of ethical integration that addresses these concerns. They do not offer watered-down versions of Buddhist practice stripped of ethical foundations; rather, they draw on their deep personal practice to offer meditation and presence in forms patients can receive while maintaining the integrity of their tradition. Lynn's insistence that effective clinical meditation requires personal practice, not just technical knowledge, exemplifies this commitment.

The distinction Wells and colleagues draw between "right mindfulness" (*sammā-sati*) as "a deeply ethical practice that is intertwined with other aspects of the Noble

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[200] Chloe Wells, William Van Gordon, and Paul Barrows, "Mindfulness and Buddhist Principles in Oncology: Risks, Misconceptions and Recommendations for Ethical Integration," *Journal of Psychosocial Oncology* 44, no. 2 (2026): 248–63, https://doi.org/10.1080/07347332.2025.2551625.

[201] Wells, Gordon, and Barrows, "Mindfulness and Buddhist Principles," 250.

[202] Wells, Gordon, and Barrows, 248.

Eightfold Path" and the secularized "mindfulness" often offered in clinical settings illuminates what participants in this study are navigating.[203] They are trained in right mindfulness through their monastic formation, yet they must offer mindfulness in clinical contexts where patients may not share or even understand the ethical framework that gives it meaning. Their solution—offering meditation while withholding terminology, adapting practices to individual needs, and maintaining their own practice as the source of their authority—represents a sophisticated response to this challenge.

Professional Identity Formation in Chaplaincy

The findings of this study contribute to the growing literature on professional identity formation in chaplaincy. Cadge and colleagues' research on chaplaincy programs in theological education documents "substantial growth in chaplaincy-focused programs in theological schools in the last 20 years" as well as "the lack of standardization across them."[204] They note that these programs "mostly developed independent of one another" and have "not come to consensus about the skills and competencies chaplains need to do their work."[205] This lack of standardization creates both challenges and opportunities for Buddhist participants, who must navigate programs shaped by diverse assumptions while advocating for their own traditions' perspectives.

The negotiation of dual identities described in this study is consistent with broader literature on professional identity in boundary-spanning roles. Lynn's "fundamental puzzle" of how to be both a good monastic and a good chaplain exemplifies the identity

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[203] Wells, Gordon, and Barrows, 252.

[204] Wendy Cadge et al., "Training Chaplains and Spiritual Caregivers: The Emergence and Growth of Chaplaincy Programs in Theological Education," *Pastoral Psychology* 69, no. 3 (2020): 187–208, https://doi.org/10.1007/s11089-020-00906-5.

[205] Cadge et al., "Training Chaplains," 187.

work needed when individuals have to integrate seemingly contradictory roles. Mona's clear differentiation between roles—functioning as a monastic with Buddhist patients and as a chaplain with others—represents one resolution to this puzzle. John's seamless integration, enabled by teacher validation, represents another. The diversity of resolutions indicates that the process of professional identity formation is not uniform but rather must consider individual and contextual variations.

Extending the Literature

This study makes several important contributions to the existing literature. First, it offers empirical support for theoretical discussions of Buddhist chaplaincy that have been mostly based on program descriptions and reflective accounts. Sanford's *Kalyāṇamitra: A Model for Buddhist Spiritual Care*, based on interviews with Buddhist chaplains and textual exploration, offers a theoretical framework that resonates with the findings of this study.[206] Sanford's argument that "spiritual friendship, or *Kalyāṇamitra*, embodies the goal of Buddhist spiritual caregiving" and that "in this capacity the chaplain walks the path with careseekers as a friend, rather than a spiritual authority" aligns with participants' descriptions of their work.[207] Lynn's emphasis on "not teaching" but walking alongside, Mona's contrast between "control, control, control" and listening, and Faye's Phantom City revelation all point toward this model of spiritual friendship rather than spiritual authority.

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[206] Sabrina Starnaman, review of *Kalyāṇamitra: A Model for Buddhist Spiritual Care*, by Monica Sanford, *The Journal of Pastoral Care & Counseling* 77, nos. 3–4 (2023): 185–86, https://doi.org/10.1177/15423050231206557.

[207] Starnaman, *Kalyāṇamitra*, 185; and Monica Sanford, "The Practice of Dharma Reflection among Buddhist Chaplains: A Qualitative Study of 'Theological' Activity among Non-Theocentric Spiritual Caregivers" (PhD diss., Claremont School of Theology, 2018).

Second, this study centers the voices of Buddhist monastics specifically, rather than lay Buddhist chaplains or monastics from other traditions. The distinctiveness of monastic formation—its emphasis on renunciation, its training in specific meditation practices, its relationship to lay communities, its embodied markers like the robe—creates particular dynamics in CPE that are not captured by studies of lay Buddhist chaplains or of monastics from traditions with different relationships to clinical work.

Third, this study implies the transformative potential of CPE for Buddhist monastics beyond professional skill development. The emotional awakening documented in Lynn and Dora's narratives, the integration of theoretical knowledge with embodied practice described by Mona, and the ongoing reflective learning that continues after the program ends for Faye all suggest that CPE functions for these participants as a form of contemplative practice in its own right—a laboratory for testing and deepening Buddhist learning through direct engagement with suffering.

Fourth, this study raises important questions about the structures of chaplaincy education that have received limited attention in the literature. Hope's call for collective Buddhist action to transform CPE programs, Wynn's questioning of whether brief hospital encounters truly benefit patients, and Mona's insistence that training remain interfaith rather than sectarian all point toward the need for ongoing critical examination of how chaplaincy education is structured and for whom.

Theoretical Contributions

Building on the findings of this study and engagement with existing literature, I offer three theoretical contributions to the understanding of Buddhist monastic

participation in CPE and, more broadly, to the study of minority religious formation in clinical contexts.

The Model of Integrative Negotiation

The first theoretical contribution is a model of integrative negotiation that illuminates how Buddhist monastics navigate the relationship between their monastic and chaplain identities. This model suggests that identity negotiation takes place on multiple dimensions (cognitive, embodied, relational, institutional) and that individuals develop strategies along a spectrum from integration to differentiation.

At one end of the spectrum is seamless integration, exemplified by John. He perceives his monastic and chaplain identities as continuous rather than separate. This integration is reinforced by foundational validation from one's own tradition—in John's case, this comes from his teachers' affirmation that chaplaincy is simply "living the Dharma." Without such validation, integration may prove much more difficult to achieve.

At the other end of the spectrum lies functional differentiation, exemplified by Mona. She maintains a sharp cognitive distinction between her two roles, deploying each according to the context. While this strategy allows for functional clarity, it demands ongoing attention to ensure the appropriate role is activated in any given situation.

Between these poles lies a middle path of continuous adjustment, exemplified by Lynn, who holds both identities in dynamic tension and continually renegotiates their relationship. This strategy requires ongoing reflective practice and a tolerance for ambiguity, but it allows for flexibility as contexts change.

The model also identifies key dimensions along which negotiation occurs. The cognitive dimension is concerned with how participants conceptualize the

relationship between their identities as continuous, separate, or dynamically related. The embodied dimension is to do with how identity is carried in physical presence, most notably in decisions about monastic attire. The relational dimension concerns the way participants engage with patients, peers, supervisors, and their own monastic communities. The institutional dimension, meanwhile, is how healthcare and training structures enable or constrain the expression of identity.

The model contributes to the literature on professional identity formation in chaplaincy by foregrounding the experiences of religious minorities and identifying the specific dimensions in which negotiation occurs. This suggests that educators and communities should support individuals in designing strategies that fit their particular contexts and temperaments, rather than prescribing a universal model of identity integration.

The Concept of Emotional Reclamation

The second theoretical contribution is the concept of emotional reclamation to describe the process by which Buddhist monastics in this study recovered access to emotional experience that had been suppressed or disconnected through monastic and cultural conditioning. This concept extends existing discussions of emotional intelligence in chaplaincy by attending to the specific dynamics of monastic formation.

Lynn's recovery of tears after ten years without crying, and Dora's discovery of her emotional "wall," exemplify this process. Both participants had developed, through monastic training and cultural conditioning, strategies for managing emotion that served protective functions but limited their capacity for genuine presence with suffering others. Through exposure to emotionally expressive peers, supervisory challenges, and direct

encounters with patient suffering, CPE catalyzed a reclaiming of emotional experience that enriched both participants' clinical work and their personal lives.

The concept of emotional reclamation carries several implications. First, it suggests that Buddhist equanimity (*upekkhā*) may sometimes be confused with emotional disconnection—a possibility that Lynn explicitly raises in her reflection on the monk who saw snow for the first time and reported "no feeling." Genuine equanimity, in the Buddhist tradition, is not the absence of feeling but freedom from being controlled by feeling. The reclamation process described by participants represents not a departure from Buddhist practice but its deepening—an integration of emotional awareness with meditative stability.

Secondly, the concept emphasizes the importance of emotional education in monastic formation. If monastics are to serve effectively in clinical contexts, their training must include opportunities to develop emotional awareness and the capacity to stay with intense emotion without fleeing or dissociating. This is not a critique of monastic training but an identification of an area where additional support may be needed for those called to clinical work.

Third, the concept suggests that emotional reclamation may be a gift that clinical work offers back to monastic communities. Dora noted that the skills of emotional presence she developed in CPE remained with her when she returned to the temple, strengthening her relationships with other monastics and laypeople. Lynn noted that she can now tell laypeople when she feels sad or frustrated, though she still cannot share such feelings with fellow monastics. This suggests that clinical training may catalyze emotional development that could eventually enrich monastic communities themselves.

The Framework of Dharma Localization

The third theoretical contribution is the framework of Dharma localization to describe how Buddhist monastics adapt and translate Buddhist teachings for clinical contexts. This framework extends the traditional Buddhist concept of skillful means (*upāya*) by attending to the specific dynamics of cross-cultural and interfaith spiritual care.

Dharma localization operates at multiple levels. At the linguistic level, participants consistently avoided traditional Buddhist vocabulary with patients, finding terms like suffering, emptiness, and impermanence "too big, too hollow" for those in crisis. Instead, they translated Buddhist insights into accessible language: "What is the issue that you're facing?" rather than "Tell me about your suffering"; "observing the pain like a wave" rather than "contemplating impermanence."

At the practical level, meditation became the primary vehicle for Dharma localization. Participants offered meditation in highly individualized forms, adapted to each patient's medical situation, personality, and cultural background. For patients in pain, body scans; for those unable to feel their bodies, meditation on the bed itself; for groups, guided practices that built connection. These adaptations drew on Buddhist principles while meeting patients exactly where they were.

At the conceptual level, participants engaged in ongoing interpretive work to connect Buddhist teachings with clinical experience. Faye's discovery of the Phantom City parable as a framework for understanding her chaplaincy role exemplifies this process. The parable, traditionally read as a teaching about the Buddha's skillful means,

became for her a revelation of what she had been doing all along: creating temporary refuge where strength could be regained for the journey ahead.

The framework of Dharma localization carries several implications. First, it positions Buddhist chaplains as translators and interpreters rather than mere technicians who apply predetermined techniques. Their deep grounding in Buddhist practice enables them to offer the essence of the Dharma in forms that patients can receive, without requiring them to adopt Buddhist frameworks.

Second, the framework recognizes that localization is not dilution but adaptation. The Dharma is not diminished when offered in accessible forms; rather, it becomes available to those who could not receive it in traditional formulations. As Faye's metaphor of the wooden bucket suggests, Buddhism that makes itself useful will be preserved; Buddhism that remains only in traditional forms may become irrelevant.

Third, the framework opens space for ongoing development of Buddhist clinical resources. Participants identified areas where further localization work is needed: meditation for specific conditions (pain, anger, and relationship issues), frameworks for addressing the "why" question, and ways to continue care after hospital discharge. These needs point toward future directions for Buddhist chaplaincy training and research.

Implications for Practice

The findings of this study carry implications for multiple stakeholders: CPE educators and supervisors, Buddhist monastic communities, Buddhist chaplaincy training programs, healthcare institutions, and Buddhist monastics themselves considering or preparing for CPE.

CPE Educators and Supervisors

For CPE educators and supervisors, this study offers several recommendations grounded in participants' experiences.

Accommodate monastic attire thoughtfully. The robe is not merely clothing but an extension of monastic identity, experienced by Dora as "my skin." While supervisors may have legitimate pedagogical reasons for asking students to experiment with secular clothes, such requests should be made with sensitivity to what the robe represents and with respect for students' need to consult their monastic communities. Arbitrary distinctions—Wynn's experience of Japanese robes being acceptable while Chinese robes were not—should be avoided.

Recognize the assets Buddhist monastics bring. Participants brought decades of meditation practice, ethical discipline, familiarity with suffering, and a quality of compassionate presence that patients could perceive. These assets should be recognized and built upon, rather than treated as obstacles to overcome. CPE educators would benefit from basic literacy in Buddhist traditions, including understanding that "atheistic" Buddhism is not a contradiction but a coherent worldview.

Support emotional development with cultural sensitivity. The emotional awakening described by Lynn and Dora was a transformative but also a challenging one. Educators need to be mindful that monastic and cultural conditioning about emotion might not be the same as Western therapeutic norms and that support for emotional development must be sensitive to those differences. The aim is not to impose Western norms of emotional expression, but rather to help students develop authentic emotional presence that works for them.

Address the "why" question explicitly. The tension between Buddhist explanatory frameworks and clinical norms that prohibit providing answers deserves explicit attention in supervision. Educators can help Buddhist students in learning how to decide when and with whom to share Buddhist perspectives, recognizing that this discernment is itself a form of clinical wisdom.

Create space for Buddhist reflection. The requirement to provide theological reflection can feel alienating when the only available frameworks are theistic. Educators can explicitly invite students to reflect using their own tradition's categories and can educate themselves enough to engage these reflections meaningfully.

Buddhist Monastic Communities

For Buddhist monastic communities whose members are considering or engaged in CPE, this study offers guidance for supporting monastics through this training.

Provide clear validation and guidance. John's teachers' affirmation that his chaplaincy work was "living the Dharma" provided foundational support that prevented identity conflict. Communities can explicitly discuss whether and how clinical chaplaincy aligns with their tradition's understanding of monastic vocation and can provide clear guidance to members undertaking this path.

Create processes for navigating institutional expectations. Dora's turning to a senior temple member before trying on secular clothes is an example of the kind of support a community can provide. Clear processes that allow monastics to share institutional expectations with community leaders can help prevent isolation and support more informed decision-making.

Address internal critique of chaplaincy work. Hope's experience of being told by a layperson that she should be "more monastic" by staying in the temple instead of doing service work points out the necessity for communities to confront misconceptions about engaged practice. Communities can educate members about the bodhisattva tradition and the long history of Buddhist service beyond temple gates.

Integrate clinical learning into ongoing formation. Participants found that skills developed in CPE—listening, emotional presence, communication—enriched their monastic lives. Communities can create spaces for monastics to share what they are learning and to explore how clinical training might inform traditional practice.

Buddhist Chaplaincy Training Programs

For programs designed to train Buddhist chaplains, this study offers insights into curriculum design and pedagogy.

Balance wisdom and compassion. Faye criticizes her tradition for privileging wisdom (*prajñā*) over compassion (*karuṇā*) and calls for training that would purposefully develop the compassionate presence. This calls for a theoretical grounding in compassion teachings and practical opportunities to develop compassionate skills.

Teach meditation for clinical contexts. Participants identified meditation as a primary clinical tool but noted that clinical meditation requires adaptation. Training programs should include instruction in how to offer meditation to diverse patients, how to adapt practices to different needs, and how to maintain personal practice as the source of clinical authority.

Address emotional development explicitly. The emotional reclamation described by participants suggests that monastic formation may not fully prepare monastics for the

emotional demands of clinical work. Training programs can include opportunities for emotional awareness work, framed as complementary development for clinical contexts, not as a critique of monastic training.

Include cross-cultural and interfaith content. Lynn's emphasis on cross-cultural psychology and knowledge of other religions points to a need for training that prepares chaplains to work with diverse patient populations. This includes both cognitive knowledge (other traditions' beliefs and practices) and practical skills (how to pray in other traditions' languages and how to participate in unfamiliar rituals).

Address the question of impact honestly. Wynn's searching questions about whether brief hospital encounters truly benefit patients deserve serious engagement. Training programs may give students the chance to think critically about the effectiveness and value of chaplaincy encounters, rather than assuming that they are inherently valuable.

Healthcare Institutions

For healthcare institutions employing Buddhist chaplains or hosting Buddhist CPE students, this study offers guidance for fostering supportive environments.

Adopt multifaith rather than interfaith models where possible. Hope's experience at Cedars-Sinai, where the multifaith model allowed her to maintain her full monastic identity, suggests that this approach may better support chaplains from minority traditions than models that require all chaplains to adopt a generic spiritual identity.

Address religious bias explicitly. Mona's experience with Korean Christian patients who pitied Buddhist nuns points to the need for institutions to address religious bias when it impacts patient care. This includes both supporting chaplains who encounter

such bias and educating patients and families about the role and value of chaplains from diverse faith traditions.

Provide language support for non-native speakers. Dora, Faye, and Mona all encountered significant language barriers. Institutions can help by providing targeted language support, embracing linguistic diversity as a strength, and establishing peer-support networks that allow non-native speakers to build confidence and thrive.

Consider post-discharge connections. Wynn's question of how to continue supporting patients after they leave the hospital, especially those who become interested in Buddhism, points to opportunities for institutions to partner with community Buddhist organizations. Such partnerships could help provide spiritual care outside the hospital.

Buddhist Monastics Considering CPE

For Buddhist monastics contemplating CPE, this study offers both realistic preparation and encouragement.

Expect challenge and transformation. Every participant in this study found CPE challenging, and most found it transformative. Monastics should enter with realistic expectations about the difficulty of the work while remaining open to the growth it may catalyze.

Seek community support. Participants who had support from their monastic communities—John's teachers, Dora's senior temple member—navigated challenges more smoothly. Before beginning CPE, monastics can discuss their intentions with community leaders and establish processes for consultation during training.

Prepare for identity questions. The negotiation of dual identities is not optional but inherent to Buddhist monastic participation in CPE. Monastics can prepare by

reflecting on their own understanding of their vocation and by considering in advance how they might navigate specific challenges (the robe, boundaries, and emotional expression).

Trust your practice. Despite the challenges, participants consistently found that their Buddhist practice was their deepest resource. Lynn's decades of meditation, John's teacher validation, Mona's compassion training—these sustained them through difficulty. Monastics can trust that their practice has prepared them for CPE, even in an unfamiliar context.

Find your own resolution. The diversity of resolutions among participants—integration, middle path, differentiation, and contextual identity—suggests that there is no single "correct" way to hold monastic and chaplain identities. Each monastic must find a resolution that works for them, in their context, with their particular gifts and limitations.

Chapter Summary

This chapter has synthesized and interpreted the findings from an interpretative phenomenological analysis of the lived experiences of seven Buddhist monastics participating in CPE. The findings suggest that CPE is experienced as a challenging yet transformative process that facilitates self-discovery, emotional awakening, and the integration of Buddhist learning in clinical practice. Depending on their personal circumstances and institutional contexts, participants employed a variety of strategies to negotiate their dual identities as monastics and chaplains, such as integration, a middle path, differentiation, contextual identity, and transcendent identity. They drew on

Buddhist teachings in sophisticated ways, strategically avoiding traditional religious vocabulary with patients while still conveying the essence of the Dharma through adapted meditation practices and compassionate presence.

The findings were discussed in relation to the literature on Buddhist chaplaincy, minority religious representation in CPE, and ethical integration of Buddhist principles in clinical contexts. This study adds to the existing literature by empirically grounding theoretical discussions of Buddhist chaplaincy, giving voice to the particular voices of Buddhist monastics, uncovering the transformative potential of CPE for this population, and posing critical questions about the structures of chaplaincy education.

Three theoretical contributions were offered: the model of integrative negotiation describing how monastics navigate dual identities; the concept of emotional reclamation describing the recovery of emotional experience suppressed through monastic and cultural conditioning; and the framework of Dharma localization describing how Buddhist teachings are adapted and translated for clinical contexts.

Implications for practice were identified for several stakeholders; CPE educators can be aware of monastic attire, recognize Buddhist assets, foster emotional development with cultural sensitivity, answer the "why" question directly, and make room for Buddhist reflection. Buddhist monastic communities can provide explicit validation, create procedures for negotiating institutional expectations, answer internal critiques of chaplaincy work, and integrate clinical learning into continuing formation. Training programs for Buddhist chaplains can balance wisdom and compassion, teach meditation in clinical settings, explicitly address emotional development, include cross-cultural

content, and honestly address questions of impact.[208] Healthcare institutions can adopt multifaith care models, address religious bias, provide language support, and facilitate post-discharge connections for patients. Buddhist monastics who consider CPE should anticipate a challenge and a transformation. They may want to find support from the community, be ready for questions about identity, trust their practice, and, in the end, find their own resolution.

The final chapter presents the conclusions of the study, summarizes its contributions, acknowledges its limitations, outlines directions for future research, and offers personal reflections on the research journey.

[208] Rong-Chi Chen, "Clinical Buddhist Chaplaincy Training Program: History of the Development of Taiwan's Clinical Buddhism," *Journal of Scientific Discovery* 1, no. 1 (2017), https://doi.org/10.24262/jsd.1.1.17005.

Chapter Six:

Conclusion

Overview of the Study

This interpretative phenomenological analysis set out to explore the lived experience of Buddhist monastics engaged in CPE in the United States. The study was motivated by a recognition that while Buddhist participation in chaplaincy is growing, and while CPE remains the primary training pathway for professional spiritual care in North American healthcare, the voices of Buddhist monastics themselves have remained insufficiently centered in empirical research. As Sanford and Michon note, "as an emerging field, there is little literature on Buddhist chaplaincy, so it is currently somewhat difficult to say what theories and practices will come to dominate the profession."[209] This study responds to that gap by providing the first systematic phenomenological investigation of how Buddhist monastics experience, interpret, and navigate CPE.

The study was guided by one central research question and two sub-questions:

Central question: How do Buddhist monastics experience and make meaning of their participation in CPE?

Sub-question 1: How do Buddhist monastics negotiate their dual roles as Buddhist renunciates and clinical spiritual caregivers within healthcare institutional contexts?

Sub-question 2: How do Buddhist monastics draw on Buddhist teachings and practices in clinical encounters and reflective learning within CPE?

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[209] Sanford and Michon, "Buddhist Chaplaincy."

Seven participants were recruited through purposive sampling—John, Dora, Hope, Faye, Lynn, Wynn, and Mona, who represented various Buddhist traditions (Tibetan Geluk and Nyingma, Chinese Mahāyāna Linji Chan, Korean Buddhist, and multi-tradition training), cultural backgrounds (American, Chinese, Korean, Vietnamese, and cross-cultural), levels of training (from first-unit students to staff chaplains with years of experience), and clinical settings (pediatric hospitals, trauma centers, cancer centers, children's hospitals, and palliative care units). The diversity of the sample, coupled with the participants' shared experience as Buddhist monastics who had completed at least one unit of CPE, provided a rich foundation for both idiographic and cross-case analysis.

Data were collected through online semi-structured interviews conducted in accordance with the IPA guidelines proposed by Smith, Flowers, and Larkin.[210] Each interview lasted approximately 40 to 120 minutes and was transcribed verbatim. Analysis followed the six-step IPA process: reading and re-reading, initial noting, developing emergent themes, searching for connections across themes, moving to the next case, and looking for patterns across cases.[211] Throughout the analytic process, attention was paid to both the particularity of each participant's account and the shared dimensions of their experience.

Six superordinate themes emerged from the analysis: (1) the negotiation of dual identities, (2) the transformation of emotional awareness, (3) the application and adaptation of Buddhist concepts in clinical contexts, (4) the navigation of cultural and religious difference, (5) the distinctive contributions of Buddhist monastics to chaplaincy, and (6) the vision for Buddhist chaplaincy training. Idiographic case studies and cross-

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[210] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*.
[211] Smith, Flowers, and Larkin, 82–101.

case synthesis were used to explore these themes in depth, generating a rich account of how participants made meaning of their CPE experiences.

The findings suggest that, for these participants, CPE is far more than a pathway to professional certification. It is a transformative experience that challenges, deepens, and sometimes radically reshapes their understanding of monastic identity and compassionate service. Depending on their personal circumstances and institutional contexts, participants navigated the "fundamental puzzle" of being both good monastics and good chaplains through strategies such as integration, the middle path, differentiation, contextual identity, and transcendent identity. They drew upon Buddhist teachings with sophisticated discernment, not using traditional vocabulary with patients, but always giving the essence of the Dharma through adapted meditation practices and compassionate presence. Their emotional landscapes were transformed through exposure to suffering, peer relationships, and supervisory challenges, restoring capacities for feelings that had been suppressed by monastic and cultural conditioning.

Key Conclusions

CPE as Transformative Formation

The first key conclusion is that, for Buddhist monastics, CPE serves as a form of transformative formation that extends beyond professional skill development to include personal, emotional, and spiritual growth. The participants in this study did not come out of CPE simply as more competent clinicians; they came out of it as changed individuals.

This change happened through several mechanisms. Direct encounters with suffering served as crucibles that tested and deepened participants' understanding of the

Buddhist teachings they had studied for years. This aspect is vividly embodied by Lynn's motivation to challenge herself and verify if she truly comprehended the suffering she spoke of. The hospital turned into a place of practice, where the Four Noble Truths were no longer mere teachings to recite but real experiences unfolding in every patient ward.

Peer and supervisor relationships provided the relational container within which difficult learning could occur. Dora's emotionally expressive peers helped her discover her own emotional "wall." Faye's peers validated her feelings of being an outsider, creating moments of genuine connection across differences. Lynn's supervisors persistently challenged her emotional absence until tears returned after ten years without crying. These relationships were not just supportive but catalytic, pushing participants toward growth they might not have achieved alone.

The reflective practices of CPE, verbatim writing, group process, and supervision provided participants with an opportunity to link their clinical experiences with Buddhist understanding. For some, such as Faye, this integration persisted long after the program ended, in the form of ongoing reflection and subsequent engagement with texts. This indicates that CPE's function is to initiate a meaning-making process that is not limited to the formal training period.

The implication of this conclusion is that CPE should be understood not merely as skills training but as formation—a process that shapes the whole person. For Buddhist monastics, this formation can complement and deepen monastic formation rather than competing with it. The emotional reclamation, self-discovery, and integration of theory with practice that participants experienced represent gifts that CPE offers back to monastic communities.

Identity Negotiation as Inherent to Buddhist Monastic Participation

The second key conclusion is that the negotiation of dual identities—monastic and chaplain—is not optional but inherent to Buddhist monastic participation in CPE. Every participant in this study engaged in this negotiation, though their strategies and resolutions varied.

This negotiation occurs because the professional expectations of chaplaincy differ significantly from traditional monastic-lay relationships in ways that demand some form of integration or differentiation. The chaplain's role is non-directive, listening rather than teaching, accompanying rather than guiding.[212] The chaplain maintains professional boundaries, scheduled availability, and documented practice. The chaplain serves patients of all traditions, adapting to their frameworks rather than expecting them to adapt to one's own. These expectations do not automatically align with monastic habits formed through years or decades of training.

The diversity of resolutions participants developed—seamless integration (John), middle path (Lynn), functional differentiation (Mona), contextual identity (Faye), transcendent identity (Wynn), institutionally supported identity (Hope), and embodied negotiation (Dora)—suggests that there is no single "correct" way to hold these roles. What matters is that participants engaged the question authentically and arrived at resolutions that allowed them to function effectively while maintaining integrity.

The implication of this conclusion is that CPE educators and Buddhist communities should support monastics in finding their own paths to resolution, rather than prescribing a particular model. Such support may include explicit discussion of

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[212] Duane R. Bidwell, "Deep Listening and Virtuous Friendship: Spiritual Care in the Context of Religious Multiplicity," *Buddhist-Christian Studies* 35 (2015): 3–13.

identity questions during supervision, opportunities to consult with monastic communities about institutional expectations, and an understanding that identity negotiation is an ongoing process, not a one-time problem.

Dharma Localization as Skilled Clinical Practice

The third key conclusion is that Buddhist monastics engage in sophisticated processes of Dharma localization—adapting and translating Buddhist teachings for clinical contexts in ways that preserve their essence while making them accessible to patients who may not share Buddhist frameworks.

This localization operates at multiple levels. At the linguistic level, participants consistently avoided traditional Buddhist vocabulary with patients, finding terms like suffering, emptiness, and impermanence too abstract for those in crisis. Instead, they translated Buddhist insights into accessible language: "What is the issue that you're facing?" rather than "Tell me about your suffering"; "observing the pain like a wave" rather than "contemplating impermanence."

At the practical level, meditation became the primary vehicle for Dharma localization. Participants offered meditation in highly individualized forms, adapted to each patient's medical situation, personality, and cultural background. Lynn's improvisation of meditation on the bed itself for a dying patient who could not feel his body exemplifies this adaptive skill—drawing on Buddhist principles of concentration while meeting the patient exactly where he was.

At the conceptual level, participants engaged in ongoing interpretive work to connect Buddhist teachings with clinical experience. Faye's discovery of the Phantom City parable as a framework for understanding her chaplaincy role exemplifies this

process—a moment of insight that transformed her understanding of what she had been doing all along.

The implication of this conclusion is that Dharma localization should be recognized as skilled clinical practice requiring both deep grounding in Buddhist tradition and sophisticated clinical discernment. Training programs can support this practice by explicitly addressing questions of translation and adaptation, by providing opportunities to practice offering meditation in varied forms, and by creating space for the interpretive work that connects Buddhist teachings with clinical experience.

Emotional Reclamation as Integration, Not Departure

The fourth key conclusion is that the emotional reclamation experienced by several participants—Lynn's recovery of tears, Dora's discovery of her emotional "wall"—represents not a departure from Buddhist practice but its deepening. These participants did not abandon equanimity; they integrated emotional awareness with meditative stability.

Lynn's reflection on the monk who saw snow for the first time at age sixty and reported "no feeling" captures the distinction. The question she poses is profound: If a monastic cannot feel excitement at a first snowfall, how can they understand a patient's feelings when facing loss or novelty? This questioning does not reject monastic training but seeks integration—emotional awareness without being controlled by emotion.

Dora discovered that her emotional "wall," reinforced by Chinese cultural norms and monastic training, limited her capacity for presence with suffering patients, which led her to begin lowering it. This was not easy—"it's so difficult to stay there" (D 11:09–12:10)—but it was necessary for the kind of presence clinical work requires. The wall

had served a protective function, but it had also protected her from the vulnerability required for genuine connection.

The implication of this conclusion is that emotional education deserves attention in both monastic formation and CPE training. For monastics called to clinical work, opportunities to develop emotional awareness and the capacity to stay with intense emotion should be available. This is not a critique of monastic training but an identification of an area where additional support may be needed for those serving in particular contexts.

The Need for Structural Change

The fifth key conclusion is that while individual monastics can and do succeed in CPE as currently structured, there remains a need for structural changes that would better accommodate Buddhist participants and, more broadly, transform chaplaincy education into something genuinely multifaith.

Hope's call for Buddhist chaplains to "band together, create a training program, and exert… be a force in itself to break down these paradigms" (H 34:08–34:30) reflects a recognition that individual excellence is not enough. The system itself requires transformation, as it is shaped by Christian assumptions, embedded in Christian language, and structured around Christian models of pastoral identity.

Mona's insistence that training should remain interfaith rather than becoming sectarian offers a constructive vision. The goal is not separate Buddhist training that would produce chaplains with "limited thought" unable to serve diverse populations. Rather, the goal is to transform existing training so that it genuinely accommodates and

draws on multiple traditions—so that Buddhist participants can participate without always translating, explaining, or navigating structures not designed for them.

Wynn's questions about whether brief hospital encounters truly benefit patients and about how to continue care after discharge point toward another dimension of structural change. Hospital chaplaincy as currently configured may not be optimally designed for the kind of spiritual support patients need. Creative partnerships between hospitals and community Buddhist organizations could extend care beyond institutional walls.

The implication of this conclusion is that advocacy and organizing are legitimate dimensions of Buddhist chaplaincy practice. Working to change the structures that shape chaplaincy education and practice is not separate from compassionate service but an expression of it—a way of ensuring that future patients and future chaplains will have better support than is currently available.

Contributions to Knowledge

This study makes several contributions to knowledge in the fields of Buddhist chaplaincy, CPE education, and the study of minority religious formation in clinical contexts.

Empirical Contribution

The primary contribution of this study is empirical: it provides the first systematic phenomenological investigation of Buddhist monastics' lived experience in CPE. While reflective accounts by Buddhist practitioners exist, and while program descriptions from

Buddhist chaplaincy training institutions are available, no previous study has centered the voices of Buddhist monastics themselves through rigorous qualitative inquiry.

The idiographic case studies presented in Chapter 4 offer rich, detailed accounts of seven individuals' journeys—accounts that honor the particularity of each participant's experience while also illuminating shared dimensions. These narratives will be valuable for CPE educators seeking to understand Buddhist students, for Buddhist monastics considering CPE, and for researchers studying minority religious participation in clinical training.

Theoretical Contribution

The study makes three theoretical contributions, articulated in Chapter 5: the model of integrative negotiation describing how monastics navigate dual identities; the concept of emotional reclamation describing the recovery of emotional experience suppressed through monastic and cultural conditioning; and the framework of Dharma localization describing how Buddhist teachings are adapted and translated for clinical contexts.

These theoretical contributions extend existing literature on professional identity formation in chaplaincy by centering the experiences of religious minorities and by identifying specific dimensions along which identity negotiation occurs. They contribute to discussions of Buddhist spiritual care by providing conceptual tools for understanding how Buddhist wisdom is actually practiced in clinical settings—not as doctrine imposed but as presence offered, not as terminology taught but as meditation adapted, not as Buddhist identity asserted but as compassionate energy shared.

The concept of emotional reclamation contributes to broader discussions of emotion in religious life by raising questions about the relationship between equanimity and emotional availability. Lynn's questioning of whether "no feeling" represents genuine freedom or emotional disconnection deserves serious engagement from Buddhist communities and from scholars of Buddhist practice.

Methodological Contribution

The study demonstrates the value of interpretative phenomenological analysis for investigating chaplaincy formation in religiously diverse contexts. CPE is inherently experiential, reflective, and relational, involving complex identity development and meaning-making that cannot be fully captured through purely outcome-oriented or competency-based approaches alone. The IPA's commitment to understanding how participants make sense of formative events, attribute meaning to challenge and growth, and construct narratives of vocation and practice was well suited to this research context.

The study also points to the importance of attending to the particularity of the religious identity in chaplaincy research. Buddhist monastics are not simply "Buddhist participants" in CPE; they bring distinctive formation, distinctive commitments, and distinctive challenges that require focused investigation. Future research on other minority religious groups in chaplaincy could benefit from similarly focused attention.

Practical Contribution

The study offers practical guidance for multiple stakeholders: CPE educators seeking to better support Buddhist students; Buddhist monastic communities whose members are considering CPE; Buddhist chaplaincy training programs designing

curricula; healthcare institutions employing Buddhist chaplains; and Buddhist monastics themselves preparing for clinical work. These implications, detailed in Chapter 5, are grounded in participants' actual experiences and represent actionable recommendations for improving practice.

The study also contributes to ongoing debate on religious diversity, inclusion, and equity within healthcare institutions. By documenting the particular challenges experienced by Buddhist monastics—language barriers, cultural differences, religious bias, institutional expectations that conflict with monastic identity—this study provides evidence to support efforts to develop more inclusive spiritual care policies and team cultures.

Limitations and Future Research

This study, like all qualitative research, has limitations that we must acknowledge.

Sample size and generalizability. IPA is concerned with depth rather than breadth, and so the sample size of seven participants is appropriate for this methodology.[213] However, the findings cannot be generalized to all Buddhist monastics in CPE. Participants in this study were predominantly from East Asian Buddhist traditions (Chinese, Korean, and Vietnamese) with one Tibetan Buddhist and one practitioner with multi-tradition training. Monastics from other Buddhist traditions (e.g., Theravāda, Japanese Zen, etc.) may have different experiences. Participants were also all engaged in CPE in the United States; experiences in other countries may differ significantly.

[213] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 51.

Language and translation. Six of seven participants were non-native English speakers. While all were proficient enough to participate in extended interviews, and while their accounts were rich and detailed, it is possible that some nuance was lost or that participants expressed themselves differently than they would have in their native languages. The study did not include translation or interpretation services, relying on participants' English proficiency.

Single time point. Interviews captured participants' reflections at a single point. For some, this was immediately after completing CPE; for others, years later. Longitudinal research following participants through CPE and into practice would reveal more about how experiences and meanings evolve.

Researcher positionality. As discussed in Chapter 3, my identity as a *bhikkhunī* in the Chinese Buddhist tradition—having completed one unit of CPE before conducting the interviews—shaped every stage of this study. While I engaged in ongoing reflexivity to monitor my influence, another researcher with different positioning might have foregrounded different themes or interpreted participants' accounts differently.

Institutional and geographic concentration. Participants were recruited from CPE programs primarily in California and the northeastern United States. Experiences in other regions, or in programs with different institutional cultures, may differ.

The findings of this study point toward multiple directions for future research.

Research with other Buddhist populations. The study was specifically on Buddhist monastics. Future research might explore the experience of lay Buddhist chaplains in CPE and whether there are different challenges and resources for those

without monastic training. Research may also include Buddhist chaplains from traditions not included in this study (e.g., Theravāda, Japanese Zen).

Longitudinal research. Following Buddhist monastics into CPE and through their first years of practice as chaplains would reveal how identity negotiation unfolds over time, how the integration of Buddhist teachings with clinical practice evolves, and how the difficulties of early practice differ from those of training.

Comparative research. Comparative studies involving Buddhist, Muslim, Jewish, and other minority-faith participants in CPE could shed light on both shared challenges and tradition-specific dynamics. Such research could help inform efforts to make CPE more genuinely multifaith.

Research on CPE outcomes for Buddhist patients. Wynn's searching questions about whether brief hospital encounters truly benefit patients point toward the need for outcome research that includes Buddhist-specific measures. Do patients who receive visits from Buddhist chaplains experience reduced spiritual distress? Do Buddhist chaplains' adaptations of meditation and other practices produce measurable benefits?

Research on institutional change. Hope's call for collective Buddhist action to transform CPE programs raises questions about how to achieve such change. Research on successful efforts to make chaplaincy education more inclusive could inform advocacy efforts.

Research on post-discharge spiritual care. Wynn's question about how to follow up with patients who become interested in Buddhism after discharge raises the need for research on models that bridge hospital and community. Pilot studies could explore the feasibility and effectiveness of partnerships between hospitals and Buddhist organizations.

Research on emotional formation in monastic contexts. Lynn's and Dora's experiences of emotional reclamation raise questions about how monastic training shapes emotional development. Further study of emotional formation across Buddhist traditions and cultural contexts may reveal both the strengths and possible limitations of current approaches.

Dharma and Ministerial Reflections

This section offers a Dharma- and ministry-based framing of what this study has meant—not only as an academic project, but also as a formative process for me as an ordained monastic and practitioner-researcher. The dissertation adopts a methodology centered on participants' lived experiences and incorporates detailed case studies, using IPA as the primary analytical tool, while situating these experiences within the social context and institutional dynamics inherent in U.S. CPE settings. Learning to work in this way—staying close to participants' language, bracketing premature theoretical assumptions, and allowing meanings to emerge through iterative interpretation—proved both challenging and a significant breakthrough. At the same time, the research process raised questions that could not be reduced to "bias" management alone: as a monastic researching in predominantly non-Buddhist clinical training environments, I repeatedly encountered issues of identity, recognition, and belonging and had to ask how to remain grounded in the Dharma while honoring the integrity of qualitative research. The reflections that follow, therefore, bring these threads together, clarifying how the study's findings, its methodology, and my own location mutually shaped one another—and what this has taught me for Buddhist ministry in contemporary U.S. clinical contexts.

The Question of Identity in Light of Anattā

One of the most contestable tensions that emerged from this study—though not from the participants themselves—concerns the apparent conflict between the Buddhist doctrine of *anattā* (non-self or non-substantiality of identity) and the central role that identity negotiation played in these monastics' experiences of CPE. If, ultimately, there is no fixed self to which monastic or chaplain identities adhere, why did most participants struggle with, reflect on, and develop strategies for holding these dual roles? Is such identity work not, from a traditional Buddhist perspective, a form of attachment to a false sense of self?

However, none of the seven participants raised this question, nor did it arise during my data analysis or writing. The reason, I believe, is both simple and profound: the participants were not engaged in abstract philosophical debate. They were engaged in the lived, embodied, and often painful work of showing up for suffering beings in clinical settings. For them, the question was never "Am I attached to a self?" but rather "How do I, as a monastic who has taken vows of renunciation, serve effectively in a hospital without betraying my training or confusing my role?" To frame their identity negotiations as a failure to internalize *anattā* would be to misunderstand both the nature of conventional reality and the purpose of monastic discipline.

From a Dharma perspective, the very fact that these monastics experience identity negotiation is not a sign of spiritual deficiency. It is a sign that they are still practitioners on the path—not buddhas who have completely exhausted the latent tendencies toward grasping. As the *Visuddhimagga* makes clear, even highly attained practitioners continue to function within conventional frameworks of role, responsibility, and relationship until

full awakening.[214] The Buddha himself referred to himself as the Tathāgata, spoke of his past lives, and gave instructions to monks and nuns about their conduct—all within the conventional truth (*sammuti sacca*) while abiding in the ultimate truth (*paramattha sacca*).[215]

Moreover, the monastic code (Vinaya) these participants have taken as their training ground is precisely a structure of conventional identity and role. It distinguishes monastics from laity, specifies what is appropriate for a *bhikkhu* versus a *bhikkhunī*, and regulates even seemingly minor aspects of deportment and speech. To observe these precepts is not to cling to a self but to voluntarily accept a form of training that protects both oneself and the community. As Thanissaro Bhikkhu has noted, the Vinaya is best understood not as a set of absolute moral commandments but as a training (*sikkhā*) that cultivates mindfulness, restraint, and consideration for others.[216]

When outsiders—whether CPE supervisors, fellow trainees, or academic observers—ask why Buddhist monastics seem "attached" to their religious identity, they may inadvertently impose a standard that even the Buddha did not demand of his fully ordained disciples. The monastics in this study were not claiming a permanent, unchanging essence. They were navigating institutional expectations that did not automatically accommodate their form of life. Hope's call for Buddhist chaplains to "band together" was not a cry of ego-clinging but a pragmatic recognition of structural

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[214] Buddhaghosa, *The Path of Purification (Visuddhimagga)*, trans. Ñāṇamoli Bhikkhu (Seattle: BPS Pariyatti Editions, 1999), 672–75 (ch. 21, on the abandonment of personality view).

[215] See, e.g., *Majjhima Nikāya* 72, "Aggi-Vacchagotta Sutta," where the Buddha refuses to affirm or deny the existence of a self while still engaging in conventional speech. *The Middle Length Discourses of the Buddha*, trans. Bhikkhu Ñāṇamoli and Bhikkhu Bodhi (Somerville: Wisdom Publications, 1995), 590–94.

[216] Thanissaro Bhikkhu, *The Buddhist Monastic Code*, 11–14.

marginalization. Lynn's integration strategy was not a failure of non-attachment but a skillful means (*upāya*) for serving patients while maintaining her vows.

Throughout my research, I approached participants not as objects of doctrinal evaluation but as fellow practitioners engaged in genuine struggle. I did not bring the question of *anattā* to them because it would have been unskillful—a form of philosophical violence that would have prioritized abstract doctrine over empathic listening. Instead, I cultivated a stance of non-judgmental presence, a discipline rooted in Buddhist contemplative practice and the methodological commitments of IPA. The commitment to bracketing one's own preconceptions aligned naturally with the Buddhist practice of equanimity (*upekkhā*) and suchness (*tathatā*)—meeting each participant's account on its own terms without forcing it into a predetermined doctrinal framework.

What I discovered, and what I believe a Dharma-informed reading of these findings confirms, is that the participants' identity negotiations are not contradictions of *anattā* but expressions of it. Each participant arrived at a different resolution: integration, middle path, functional differentiation, contextual identity, transcendent identity, institutionally supported identity, and embodied negotiation. None of them claimed that their chosen strategy was the "true" or "eternal" way to be a monastic. Each acknowledged, implicitly or explicitly, that their identity was contingent, contextual, and constructed. This is precisely what *anattā* looks like in lived experience—not the absence of role or self-reference but the recognition that all roles are dependently originated (*pratītyasamutpāda*), without fixed essence.

In light of this, we do a disservice to Buddhist monastics—and to the Dharma itself—when we use *anattā* as a cudgel to beat down conventional identity negotiations.

The path does not ask monastics to abandon all sense of role or responsibility. It asks them to hold those roles without grasping, to enact those responsibilities without self-congratulation, and to remain aware that even the most carefully negotiated identity is, ultimately, a skillful means—a phantom city, as Faye discovered, where beings may rest before continuing their journey.

When Research Assumptions Meet Lived Experience

The second question that has shaped my own ministerial reflection concerns the relationship between my initial research assumptions and what I actually found. When I drafted my dissertation proposal, I conceived of applying a specific hermeneutic framework derived from the Three Truths (*san di* 三諦) of Tiantai Buddhism (*Tiantai zong* 天台宗): the truth of emptiness (*kong* 空), the truth of provisional existence (*jia* 假), and the truth of the middle (*zhong* 中).[217] I hypothesized that participants would spontaneously interpret their CPE experiences through these categories. Thus, I sought to interpret Buddhist monastics' real-world practices in hospital settings—including their engagement with CPE training approaches, supervisors, peer cohorts, patients, and clinical contexts—as embodying the truth of provisional existence, or the conventional truth (*saṃvṛti-satya*) according to Nāgārjuna. I regarded the core Buddhist tenets of suffering, impermanence, and non-self, upon which they reflected as Dharma practitioners, as representing the truth of emptiness, or Nāgārjuna's ultimate truth (*paramārtha-satya*). And I intended to treat the reconciliations and coping strategies they eventually arrived at in the face of various challenges, confusions, and contradictions,

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[217] Brook A. Ziporyn, *Emptiness and Omnipresence: An Essential Introduction to Tiantai Buddhism* (Bloomington: Indiana University Press, 2016), 147–56.

along with the wisdom truly gained through practice, as the truth of the middle, or the Middle Way (*madhyamā-pratipad*).[218]

After interviewing only two or three participants, I discovered that my preconceptions had influenced the development of these hypotheses. Although my interview protocol asked directly about Buddhist teachings that informed their clinical practice, participants rarely made relevant references when describing their CPE experiences. The philosophical framework I had envisioned for this study proved difficult to establish coherently based on their narratives. At first, this brought me slight disappointment. Had I imposed a conceptual framework foreign to the actual lived experience of Buddhist monastics engaged in clinical pastoral practice? But as I continued interviewing and, later, engaged in phenomenological analysis, a different understanding emerged through further reflection.

The three interrelated dimensions that actually emerged from this study—integrative negotiation, emotional reclamation, and Dharma localization—can be fruitfully understood through the lens of Tiantai Buddhism's doctrine of the Perfect Integration of the Three Truths (*san di yuanrong* 三諦圓融). This is not to retroactively impose a hermeneutic framework that participants themselves did not invoke. Rather, it is to suggest that what participants lived, often without naming, resonates deeply with

[218] Jay L. Garfield, trans., *The Fundamental Wisdom of the Middle Way: Nāgārjuna's Mūlamadhyamakakārikā* (New York: Oxford University Press, 1995).

Tiantai's distinctive understanding of reality as simultaneously empty, provisionally existent, and middle.[219] Further details are provided in the following section.

This framework illuminates the findings of this study in ways that the participants' own silence on Buddhist philosophical terminology does not negate but rather confirms. The absence of explicit doctrinal language is not the absence of Dharma; it is the Dharma manifesting in its most authentic form—as lived wisdom, responsive to context, and often operating beneath the level of explicit conceptual articulation.

My initial hypothesis had assumed that Dharma manifests primarily as explicit teaching—that monastics would name Buddhist doctrines and apply them consciously to clinical situations. What I discovered is that the Dharma can be embodied without being named. Participants were living the middle way, negotiating emptiness, and manifesting provisional truth without once using those terms. This is not a failure of Buddhist formation. It is a mark of deep formation, the kind that does not need to announce itself.

This finding has transformed my own understanding of what it means to do Buddhist-identified research. A truly Buddhist methodology cannot demand that participants speak in Buddhist categories. To do so would be to prioritize the researcher's conceptual framework over participants' lived experience—precisely the opposite of IPA's commitment to the emic perspective.[220] The Dharma, as the *Diamond Sūtra* reminds us, is like a raft: useful for crossing, but not to be carried on one's head

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[219] See Ziporyn, *Emptiness and Omnipresence*, for a comprehensive overview of the three truths and their perfect integration. The Tiantai school's innovation was to add a third truth (the middle) to the Madhyamaka two truths (conventional and ultimate), treating all three as mutually inclusive rather than hierarchical.

[220] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 41–43 (on the emic orientation of IPA).

after reaching the far shore.[221] My initial hermeneutic framework was a raft I was prepared to carry. The participants demonstrated to me that one can reach the far shore—compassionate presence, skillful adaptation, and honest emotional engagement—without ever naming the raft.

My reflection, therefore, is one of gratitude for unfulfilled expectations. Otherwise, I would have learned something about how Buddhist monastics talk about CPE. Instead, I learned something more valuable: that the Dharma works in and through Buddhist practitioners even when they are not explicitly teaching it, even when they are just trying to be present to a suffering patient, even when they are struggling with their own vulnerability. The Dharma is not primarily a set of propositions to be sought. It is a way of seeing, a way of being, a way of responding—and sometimes the most authentic expression of the Dharma is the monastic who simply sits beside a dying patient without saying anything at all.

A Triple Hermeneutic Through Tiantai's Three Truths

In IPA's double hermeneutic, participants interpret their lived experiences, and the researcher, in turn, interprets the participants' interpretations.[222] In this section, I make an additional, explicit interpretive move—a kind of triple hermeneutic: as a Buddhist practitioner and ministerial researcher, I bring a Buddhist doctrinal and contemplative framework (e.g., Tiantai's perfect integration of the three truths) to interpret my own prior interpretive account of the data. This third layer is not intended to override participants' meanings or to force the findings into doctrinal categories. Rather,

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[221] Diamond Sūtra, ch. 6, in *The Diamond Sūtra: The Perfection of Wisdom*, trans. Red Pine (Washington, D.C.: Counterpoint, 2001), 126–28 (the raft parable).

[222] Smith, Flowers, and Larkin, *Interpretative Phenomenological Analysis*, 187.

it is offered as a reflexive and ministerial act: resituating the phenomenological themes within a Dharma horizon so that the research can speak not only about Buddhist monastics in CPE but also directly to Buddhist formation and pastoral practice in ways that remain faithful to both the empirical material and the transcendental insights of Buddhist ministry.

Master Zhi Yi (智顗, 538–597 CE), also known as Master Tiantai or Zhi Zhe (智者, the Wise One), was the actual founder of the Tiantai School of Chinese Mahāyāna Buddhism. A distinguished Buddhist thinker and systematizer in the Sui and Chen dynasties, he synthesized Indian Mahāyāna doctrines (especially the Lotus Sutra and Nāgārjuna's Madhyamaka) with Chinese Buddhist insights, establishing the first comprehensive and indigenous Chinese Buddhist system.[223] At the core of Tiantai's philosophy lies the Threefold Truth, also called the Perfect Integration of the Three Truths, Zhi Yi's most influential doctrinal innovation. Derived from Nāgārjuna's *Mūlamadhyamakakārikā*—all phenomena arise from causes and conditions; hence, they are empty, provisionally named, and embody the Middle Way—it reinterprets and transcends the traditional Two Truths (conventional and ultimate).[224]

In Tiantai doctrine, emptiness, provisional existence, and the middle are neither three separable metaphysical layers nor a linear ladder of spiritual attainment. Rather,

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[223] Ziporyn, *Emptiness and Omnipresence*, on the two-truths theory in pre-Tiantai Buddhism, Mahāyāna approaches to emptiness, and the highlights of the Lotus Sūtra within the Tiantai context.

[224] Nāgārjuna, *Nāgārjuna's Middle Way: The Mūlamadhyamakakārikā*, trans. Mark Siderits and Shōryū Katsura, Classics of Indian Buddhism (Boston: Wisdom Publications, 2013), 24.8: "The Buddha's teaching of the Dharma is based on two truths: a truth of worldly convention, and an ultimate truth;" and 24.18: "Whatever is dependent origination, we call it emptiness. That is (also) dependent conceptualization; that is, to be sure, the Middle Way."

they are simultaneously operative perspectives on any lived phenomenon.[225] In this sense, the study's three theoretical findings—integrative negotiation, emotional reclamation, and Dharma localization—can be read as phenomenological sites where the Three Truths become visible—not as abstract doctrine imposed on experience but as a hermeneutic that illuminates what the participants were already doing in practice.

Integrative negotiation, for instance—especially in the form of identity negotiation across clinical, institutional, and religious contexts—provides the clearest entry point for a Tiantai reading. The participants' narratives repeatedly showed that "identity" was neither a stable essence nor merely a social label. Instead, it appeared as something dependently arisen, situationally configured, and ethically negotiated. That trifold character maps naturally onto the Three Truths.

Emptiness truth: identity as nonessential and ungraspable. In Tiantai terms, the most basic insight is that "identity" has no fixed self-nature. What appears as "monastic identity," "chaplain identity," "Asian identity," or "Buddhist identity" is not an ontological core but a contingent configuration shaped by causes and conditions—ordination lineage, institutional expectations, racialized perception, language, professional role, and the immediate needs of patients and staff. This is precisely what the truth of emptiness reveals: identity lacks an independent essence.[226]

Crucially, this means identity is real, but it is not something one can possess absolutely. When participants experienced misunderstanding, stereotyping, or pressure to perform a legible role, the discomfort often revealed how easily "identity" becomes

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[225] Ziporyn, *Emptiness and Omnipresence*, esp. on the mutual inclusion and simultaneity of the three truths.

[226] Paul L. Swanson, *Foundations of T'ien-T'ai Philosophy: The Flowering of the Two Truths Theory in Chinese Buddhism* (Berkeley: Asian Humanities Press, 1989), on Tiantai's development of emptiness/provisionality beyond a simple dualism.

reified—how quickly it can be grasped as something to defend or prove. From the standpoint of Buddhist practice, this is not simply a sociological problem but a classical expression of clinging (*upādāna*)—a suffering mechanism that CPE tends to expose with unusual clarity.

Provisional truth: identity as functionally real in relational worlds. At the same time, Tiantai insists that emptiness must be perfectly integrated with the provisional. Identity is empty, yet it appears and functions. The robe, the title "Venerable," the expectation of spiritual composure, the perception of foreignness, and the institutional role of "chaplain"—these are all provisionally real in the clinical environment. They shape access, trust, authority, vulnerability, and relational dynamics. Identity therefore becomes a real pastoral factor: it conditions how patients approach the monastic, how staff interpret their presence, and how the monastic navigates boundaries and care.

This is why identity emerges as "significant" in the data: not because Buddhism contradicts itself, but because clinical environments intensify provisional realities. The participants' accounts show identity not as metaphysical selfhood but as lived relational visibility—sometimes supportive, sometimes burdensome, always consequential.

Middle truth: negotiation as non-dual integration rather than compromise. What is distinctive in Tiantai is that the middle truth is not a bland moderation between emptiness and provisional existence. It is their non-dual integration: emptiness is precisely the provisional, and the provisional is exactly emptiness—fully "both/and" without

collapsing into either extreme.[227] In the lived experiences of the participants, negotiation and balancing served as practical enactments of this middle ground.

For example, in cases like Lynn, negotiation did not mean merely splitting the difference between "being a monastic" and "being a CPE chaplain." Rather, it looked like a situated discernment: when to be visibly monastic as a source of stability and trust, when to translate practices into non-sectarian language, when to accept institutional norms, and when to maintain Vinaya-based boundaries. This form of negotiation is not best understood as identity dilution; it is better understood as middle-way skillfulness rooted in the recognition that identity is empty (there is no fixed self to defend) yet provisionally real (role and perception still matter) and therefore must be engaged compassionately and wisely within conditions.

Reading through Tiantai's Three Truths, integrative negotiation becomes a lived demonstration of how Buddhist monastics in CPE environments are repeatedly invited to practice the middle: not by retreating into metaphysical speech, but by responding to the clinical world with flexible integrity.

This same Tiantai framework can also illuminate the other two emergent dimensions: Emotional reclamation can be understood as the reclaiming of the provisional truth of affect—grief, anger, fear, and tenderness—as genuinely present and ethically meaningful, without reifying emotion as "self" (emptiness) and without suppressing it through spiritual idealization (middle). The middle truth here is neither

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[227] Ziporyn, *Emptiness and Omnipresence*, on the "perfect" (圓) integration in which emptiness, provisional existence, and the middle are immediately co-present in any phenomenon.

emotional indulgence nor emotional denial, but compassionate intimacy with experience as it dependently arises.

Dharma localization reflects the middle truth at the cultural-linguistic level: avoiding the extremes of rigid traditionalism (refusing translation) and total assimilation (erasing Buddhist distinctiveness). Translation, adaptation, and contextual responsiveness become the lived middle, in which emptiness (non-attachment to fixed forms) and provisional existence (the concrete forms needed to communicate and care) are integrated.

Interpreting these themes through Tiantai's perfect integration of the three truths helps address a central tension that otherwise appears in the project: the data often sounded "not explicitly Buddhist," yet the life worlds described were profoundly resonant with Buddhist insights. A Tiantai hermeneutic suggests that this is not accidental. The participants may not have named emptiness, provisional existence, or the middle as doctrinal categories, but their lived experience repeatedly displayed the structure of the Three Truths in action—especially where identity and role were negotiated under the pressures of clinical practice.

In this way, the Perfect Integration of the Three Truths does not function here as an external doctrinal grid imposed onto the data. Rather, it offers a rigorous Buddhist account of why the most "ordinary" parts of the narratives—identity friction, emotional complexity, and cultural translation—can be read as sites where Dharma is already operating as integrated wisdom in everyday conditions.

Reflexive and Personal Reflections

As I complete this dissertation, I return to the reflexive statement with which I began. My position as a Buddhist monastic and international student in the United States has shaped this project at every stage—from the questions I chose to ask to the ethical stances I adopted in the field to the interpretive lenses I brought to the data. The dual vantage point of insider and outsider, contemplative and academic, has been both a source of tension and a wellspring of insight. In turn, the research process has shaped me by deepening my understanding of cross-cultural dialogue, challenging some of my prior assumptions, and prompting me to reconsider my own monastic practice within the broader contexts of migration, identity, and knowledge production.

This study and its research questions were designed and formulated before I started my CPE. As a consequence, my understanding of CPE was not comprehensive but rather gained through informal conversations with teachers and fellow students and through the partial perspectives in the relevant literature. I approached the research process with great curiosity, some preconceptions about what participants might say in interviews, and a tendency to pre-structure possible findings through a preferred theoretical lens. This positioning shaped my initial methodological choices and was both a strength and a limitation: it helped me to focus my inquiry and develop an initial interview guide, but it also risked directing my attention to confirmatory evidence and narrowing my openness to accounts that did not fit my initial expectations.

After completing one unit of CPE, I proceeded with data collection and analysis. I treated my shifting positionality as an analytic resource that also required ongoing vigilance. My CPE experience expanded my interpretive horizon: I could better recognize

what participants meant when they spoke about the intensity of clinical encounters, the complexity of peer dynamics, and the vulnerability of supervision. This increased familiarity also carried an alternative risk—taking certain experiences for granted or reading my own meanings into the participants' narratives. To counterbalance this, I intentionally retained an "informed but curious" stance in interviews, asking participants to explain what might otherwise be assumed as obvious and inviting concrete examples and counterexamples. In reflexive and analytic memos, I noted when an interpretation seemed to be influenced by my own CPE experience and returned to the transcript to consider whether a given claim was grounded in the participant's meaning-making or shaped by my own narrative.

The participants in this study gave generously of their time and themselves. They shared stories of struggle and growth, failure and insight, confusion and clarity. They entrusted me with experiences that were sometimes painful, sometimes embarrassing, and always deeply personal. I hope I have honored that trust by representing their stories with care and integrity.

Several moments from the interviews stay with me: Lynn describing the return of tears after ten years without crying; Dora discovering her emotional "wall" and beginning to lower it; Faye recounting her painful visit to the woman in unrelieved pain and her later breakthrough with the Phantom City parable; Hope naming the power dynamics embedded in chaplaincy and calling for collective action; John's teachers affirming that his chaplaincy work was "living the Dharma"; Wynn's honest questioning of whether the "gem" of Buddhist wisdom is ever truly received; and Mona's clear distinction between monastic and chaplain, along with her insistence that training remain interfaith.

These voices have taught me about courage, about honesty, about the willingness to grow even when growth is painful. They have taught me that the negotiation between monastic and chaplain identities is not a problem to be solved but a question to be lived—a question that, if engaged authentically, can lead to deeper integration rather than fragmentation.

They have also taught me about the limitations of our current structures. Hope's critique, Wynn's questions, Mona's concerns about sectarian training—these are not complaints but invitations. They invite us to imagine chaplaincy education that genuinely serves all traditions, spiritual care that continues after hospital discharge, and training that prepares chaplains not only for clinical competence but also for compassionate presence.

As I prepare to enter chaplaincy practice myself, I carry these voices with me: John's integration, Lynn's middle path, Mona's clarity of differentiation, Dora's openness to emotion, Faye's willingness to learn from failure, Hope's critical consciousness, and Wynn's honest questioning. I have come to recognize that there is no single way to be a Buddhist monastic chaplain—only the ongoing work of finding one's own way within one's own context, with one's own gifts and limitations. I also thank the participants who made this research possible, my advisors for their guidance, the IBEF Scholarship for its support, and the patients and families who will benefit from it.

Final Remarks

This study began with a simple question: How do Buddhist monastics experience CPE in the United States? Seven participants answered that question with honesty, depth, and vulnerability. Their narratives indicate CPE as a transformative mode of training that

both challenges and enriches monastic identity, elicits emotional awakening, and calls for the skillful use of Buddhist wisdom in clinical settings. Their experiences highlight both the possibilities and the limits of existing structures of chaplaincy education, and their visions for the future point to places where change is needed. Included in this change is more curricular flexibility to accommodate non-Western spiritual frameworks and more intentional support for monastics navigating dual vocational commitments.

The findings of this study matter for several reasons: they are relevant to CPE educators seeking to better serve Buddhist students, to Buddhist monastic communities whose members are considering clinical work, to Buddhist chaplaincy training programs designing curricula, to healthcare institutions employing Buddhist chaplains, and to Buddhist monastics themselves, who may find companionship in these narratives for their own journeys. Taken together, these findings illuminate the underexplored intersections between Buddhist monastic formation and clinical pastoral practice.

These findings also speak to broader discussions of religious pluralism in American health care. As the patient population grows more diverse and as spiritual care departments are committed to serving individuals of all traditions, it is important to understand how chaplains from minority traditions experience their formation. Buddhist monastics are not the only ones who must navigate structures not designed for them. Muslim, Hindu, Sikh, and other minority religious chaplains face similar challenges. This study may therefore help clarify dynamics beyond the Buddhist context. Moreover, it calls for greater institutional recognition of the distinctive spiritual resources and challenges that Buddhist monastics bring to chaplaincy roles and for a more inclusive understanding of pastoral care across religious traditions.

Wynn's metaphor for Buddhism as a "gem" that patients may not have the energy to receive captures a central tension in clinical spiritual care. The chaplain offers something precious, but the patient in crisis may lack the capacity to take it in. What, then, is the value of the work? Lynn's answer—that she plants "good seeds" that may bear fruit in future lives—draws on Buddhist psychology to sustain meaning in the face of uncertainty. Wynn's honest question—why "we spend time" if patients "get nothing"—refuses easy answers and demands ongoing reflection.

Between these positions lies the reality that chaplains inhabit daily: the work is valuable, but its value cannot always be measured in visible outcomes. The seeds planted may grow when we are not there to see them. The presence offered may be received in ways the patient cannot express. The "stone impression" of Buddhism that patients carry out of the hospital may, in ways unknown to us, become something more.

Faye's metaphor of the wooden bucket returns to me as I conclude. The piece of wood left in the forest, unused, rots. But the same wood made into a bucket becomes useful—sought out, preserved. Buddhism, which proves useful in hospitals and serves as a vessel for holding tears and a tool for clearing away despair, will be preserved. The hospital is not a threat to Buddhist identity but an opportunity for Buddhist relevance. And the chaplain, however aware of her own limitations, becomes in her very presence what Faye discovered in the Lotus Sutra—a phantom city, a temporary refuge where strength can be regained for the journey ahead.

The participants in this study have become such refuges for numerous patients and families. They have sat with the dying, held space for the grieving, and offered presence to the fearful. They have adapted their tradition's wisdom to serve those who

cannot receive it in traditional forms. They have navigated structures not designed for them while maintaining integrity. They have discovered ways to excel as both monastics and chaplains, not by permanently solving the puzzle, but by navigating it daily, patient by patient, encounter by encounter.

This dissertation is, in the end, a tribute to them—to John, Dora, Hope, Faye, Lynn, Wynn, and Mona. Their voices deserve to be heard. Their experiences deserve to be understood. Their work deserves to be supported. May this study contribute, in some small way, to that hearing, that understanding, that support. And may the patients and families they serve—and all those who will be served by Buddhist chaplains in years to come—receive the compassionate presence that these seven monastics have so generously offered.

Bibliography

Akkerman, Sanne F., and Arthur Bakker. "Boundary Crossing and Boundary Objects." *Review of Educational Research* 81, no. 2 (2011): 132–69. https://doi.org/10.3102/0034654311404435.

Ambedkar, B. R. *The Buddha and His Dhamma*. Bombay: Siddharth College Publication, 1957.

Andrus, Marc. *Brothers in the Beloved Community: The Friendship of Thich Nhat Hanh and Martin Luther King Jr.* Berkeley: Parallax Press, 2021.

Asquith, Glenn H. "Anton T. Boisen and the Study of 'Living Human Documents.'" *Presbyterian Historical Society* 60, no. 3 (1982): 244–65. https://www.jstor.org/stable/23328440.

ACPE. "ACPE Brief History." Accessed January 15, 2026. https://acpe.edu/docs/default-source/acpe-history/acpe-brief-history.pdf.

ACPE. "ACPE Outcomes and Indicators." Accessed January 15, 2026. https://www.manula.com/manuals/acpe/acpe-manuals/2016/en/topic/acpe-outcomes-and-indicators.

Association of Professional Chaplains. "BCCI Certification Manual." Accessed March 11, 2026. https://www.apchaplains.org/bcci-site/about-bcci/bcci-certification-manual/.

Bangkok Public Relations. "Bangkok's New Approach to Monk Healthcare: Where Medicine Meets Tradition." Published February 22, 2025. https://pr-bangkok.com/?p=468648.

Bark, Seong Hui. "Buddhist Chaplain Role in Hospitals: Exploring Spiritual Care Through Storytelling Using the Framework of the Four Noble Truths." DBMin. Diss., University of the West, 2024.

Berman, Michael. "Religion Overcoming Religions: Suffering, Secularism, and the Training of Interfaith Chaplains in Japan." *American Ethnologist* 45, no. 2 (2018): 228–40. https://doi.org/10.1111/amet.12634.

Bidwell, Duane R. "Deep Listening and Virtuous Friendship: Spiritual Care in the Context of Religious Multiplicity." *Buddhist-Christian Studies* 35 (2015): 3–13.

Buddhaghosa. *The Path of Purification (Visuddhimagga)*. Translated by Ñāṇamoli Bhikkhu. Seattle: BPS Pariyatti Editions, 1999.

Cabot, Richard C. “A Plea for a Clinical Year in the Course of Theological Study.” In *Adventures on the Borderlands of Ethics*, 1–22. New York and London: Harper & Brothers, 1926.

Cadge, Wendy. *Paging God: Religion in the Halls of Medicine*. Chicago: University of Chicago Press, 2012.

Cadge, Wendy, Irene Elizabeth Stroud, Patricia K. Palmer, George Fitchett, Trace Haythorn, and Casey Clevenger. “Training Chaplains and Spiritual Caregivers: The Emergence and Growth of Chaplaincy Programs in Theological Education.” *Pastoral Psychology* 69, no. 3 (2020): 187–208. https://doi.org/10.1007/s11089-020-00906-5.

Carr, Gary. “Understanding Clinical Pastoral Education for Chaplains.” The Wesleyan Church. Published October 1, 2025. https://www.wesleyan.org/understanding-clinical-pastoral-education-for-chaplains.

Chân Không. *Learning True Love: How I Learned and Practiced Social Change in Vietnam*. Berkeley: Parallax Press, 1993.

Chen, Ching-Yu. “Clinical Buddhist Chaplain-Based Spiritual Care in Taiwan.” *Taiwan Journal of Hospice Palliative Care* 17, no. 3 (2012): 300–309.

Chen, Rong-Chi. “Clinical Buddhist Chaplaincy Training Program: History of the Development of Taiwan’s Clinical Buddhism.” *Journal of Scientific Discovery* 1, no. 1 (2017). https://doi.org/10.24262/JSD.1.1.17005.

Council for Clinical Training. “Council for the Clinical Training of Theological Students records, circa 1923–1949.” Burke Library at Union Theological Seminary, Columbia University in the City of New York. Accessed March 11, 2026. https://findingaids.library.columbia.edu/archives/cul-6351504.

Dayal, Har. *The Bodhisattva Doctrine in Buddhist Sanskrit Literature*. London: Kegan Paul, Trench, Trubner & Co., 1932.

Dewey, John. *How We Think: A Restatement of the Relation of Reflective Thinking to the Educative Process*. Boston: D.C. Heath, 1933.

Doehring, Carrie. *The Practice of Pastoral Care: A Postmodern Approach*. Louisville, Ky.: Westminster John Knox Press, 2006.

Dörfler, Viktor, and Marc Stierand. “Bracketing: A Phenomenological Theory Applied through Transpersonal Reflexivity.” *Journal of Organizational Change Management* 34, no. 4 (2021): 778–93. https://doi.org/10.1108/JOCM-12-2019-0393.

Dunbar, H. Flanders. *Emotions and Bodily Changes: A Survey of Literature on Psychosomatic Interrelationships 1910–1933*. New York: Columbia University Press, 1935.

Eatough, Virginia, and Jonathan A. Smith. “Interpretative Phenomenological Analysis.” In *The SAGE Handbook of Qualitative Research in Psychology*, edited by C. Willig and W. Stainton Rogers, 193–211. London: SAGE Publications, 2017.

Finlay, Linda. “A Dance Between the Reduction and Reflexivity: Explicating the ‘Phenomenological Psychological Attitude.’” *Journal of Phenomenological Psychology* 39 (June 2008): 1–32. https://doi.org/10.1163/156916208X311601.

Fisher, Danny. “Benefit Beings!: The Buddhist Guide to Professional Chaplaincy.” PhD diss., University of the West, 2013.

Ford, Tim. “Interacting with Patients of a Different Faith: The Personal Reflection of a Buddhist Chaplain.” *Southern Medical Journal* 99, no. 6 (2006): 658–60.

Garfield, Jay L., trans. *The Fundamental Wisdom of the Middle Way: Nāgārjuna’s Mūlamadhyamakakārikā*. New York: Oxford University Press, 1995.

Gauthier, Jitsujo T. “American Buddhist Chaplaincy Supervision.” In *The Oxford Handbook of American Buddhism*, edited by Ann Gleig and Scott A. Mitchell, 446–61. New York: Oxford University Press, 2024. https://doi.org/10.1093/oxfordhb/9780197539033.013.27.

Gauthier, Jitsujo T. “Buddhist Chaplaincy.” In *The Oxford Handbook of Buddhist Practice*, edited by Kevin Trainor and Paula Arai, 564–80. New York: Oxford University Press, 2022. https://doi.org/10.1093/oxfordhb/9780190632922.013.34.

Gauthier, Jitsujo T. “Formation and Supervision in Buddhist Chaplaincy.” *Reflective Practice: Formation and Supervision in Ministry*. 37 (2017): 185–201.

Gauthier, Jitsujo T., Daijaku Judith Kinst, Leigh Miller, and Elaine Yuen. “The Path to Buddhist Chaplaincy in the United States.” In *Refuge in the Storm: Buddhist Voices in Crisis Care*, edited by Nathan Jishin Michon, 223–32. Berkeley: North Atlantic Books, 2023.

Gebert, Andrew. “Sōka Gakkai.” In *Oxford Research Encyclopedia of Religion, edited by John Barto*n. New York: Oxford University Press, 2024. https://doi.org/10.1093/acrefore/9780199340378.013.196.

Giles, Cheryl A., and Willa B. Miller, eds. *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*. New York: Oxford University Press, 2015.

Glasdam, Stinne, Katharina Ó. Cathaoir, and Sigrid Stjernswärd. “Balancing Different Legal and Ethical Requirements in the Construction of Informed Consents in Qualitative International Collaborative Research Across Continents – Reflections From a Scandinavian Perspective.” *Journal of Academic Ethics* 23, no. 2 (2025): 349–62. https://doi.org/10.1007/s10805-024-09536-5.

Glassman, Bernie. *Instructions to the Cook: A Zen Master’s Lessons in Living a Life That Matters*. New York: Bell Tower, 1996.

Glassman, Bernie. *Bearing Witness: A Zen Master’s Lessons in Making Peace*. New York: Bell Tower, 1998.

Gleig, Ann. “Engaged Buddhism.” In *Oxford Research Encyclopedia of Religion*, edited by John Barton. New York: Oxford University Press, 2021. https://doi.org/10.1093/acrefore/9780199340378.013.755.

Grimell, Jan. “‘Am I a Priest in the Armed Forces, or a Soldier Who Is a Priest?’ Identity Work among Military Chaplains in the Swedish Armed Forces.” *Frontiers in Sociology* 10 (October 2025). https://doi.org/10.3389/fsoc.2025.1645776.

Guillemin, Marilys, and Lynn Gillam. “Ethics, Reflexivity, and ‘Ethically Important Moments’ in Research.” *Qualitative Inquiry* 10 (April 2004): 261–80. https://doi.org/10.1177/1077800403262360.

Heidegger, Martin. *Being and Time*. Translated by John Macquarrie and Edward Robinson. New York: Harper & Row, 1962.

Hirsch, Trudi Jinpu. “The 4 Noble Truths as a Framework for Contemplative Care.” In *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*, edited by Cheryl A. Giles and Willa B. Miller, 143–60. New York: Oxford University Press, 2015.

Holifield, E. Brooks. *A History of Pastoral Care in America: From Salvation to Self-Realization*. Nashville: Abingdon Press, 1983.

Hsing Yun. *For All Living Beings: A Guide to Buddhist Practice*. Los Angeles: Buddha's Light Publishing, 2010.

Hsing Yun. *Humanistic Buddhism: A Blueprint for Life*. Los Angeles: Buddha's Light Publishing, 2008.

Ibarra, Herminia. "Provisional Selves: Experimenting with Image and Identity in Professional Adaptation." *Administrative Science Quarterly* 44, no. 4 (December 1999): 764–91. https://doi.org/10.2307/2666995.

Idukki, Ajayan. "Young Bodhisattvas Pave the Way for Socially Engaged Buddhism." Buddhistdoor Global. Published November 14, 2025. https://www.buddhistdoor.net/features/young-bodhisattvas-pave-the-way-for-socially-engaged-buddhism/.

Institute of Buddhist Studies. "MDiv in Buddhist Chaplaincy." Accessed January 15, 2026. https://www.shin-ibs.edu/academics/mdiv/.

Kasai, Kenta. "Introducing Chaplaincy to Japanese Society: A Religious Practice in Public Space." *Journal of Religion in Japan* 5, no. 2–3 (2016): 246–62.

King Chulalongkorn Memorial Hospital. "Department of Ceremony." Accessed March 12, 2026. https://kcmh.chulalongkornhospital.go.th/en/dept/department-of-ceremony-en/.

King, Martin Luther, Jr. "Letter from Dr. Martin Luther King, Jr. Nominating Thich Nhat Hanh for the Nobel Peace Prize in 1967." January 25, 1967. Plum Village. Accessed April 23, 2026. https://plumvillage.org/letter-from-dr-martin-luther-king-jr-nominating-thich-nhat-hanh-for-the-nobel-peace-prize-in-1967.

Klitzman, Robert L. *Doctor, Will You Pray for Me? Medicine, Chaplains, and Healing the Whole Person*. New York: Oxford University Press, 2024.

Klitzman, Robert. "How Chaplains Can Help the Fractured U.S. Health Care System." STAT. Published November 14, 2024. https://www.statnews.com/2024/11/14/chaplains-hospitals-health-care-burn-out-religion-mortality/.

Kongtrul, Dzigar, and Helen Berliner. *It's Up to You: The Practice of Self-Reflection on the Buddhist Path*. Boulder, CO: Shambhala Publications, 2006.

Kusala, Bhante. "Can a Buddhist Monk Become a Chaplain?" Harvard Divinity Bulletin. Accessed March 11, 2026. https://bulletin.hds.harvard.edu/can-a-buddhist-monk-become-a-chaplain/.

LaBat, Sean J. *Anton Boisen: Madness, Mysticism, and the Origins of Clinical Pastoral Education*. Lanham: Lexington, 2021.

Lancaster, Lewis R. "Ethics and Humanistic Buddhism." *Hsi Lai Journal of Humanistic Buddhism* 2 (2001): 31–38.

Lartey, Emmanuel Y. In *Living Color: An Intercultural Approach to Pastoral Care and Counseling*. 2nd ed. London: Jessica Kingsley Publishers, 2003.

Lee, Linda Yin King, Mimi Mei Ha Tiu, Lisa Pau Le Low, Vincent Shing Cheng, Sui Yu Yau, and Oluwadamilare Akingbade. "Navigating Challenges in Using Interpretative Phenomenological Approach with Photovoice: A Systematic Review." *International Journal of Qualitative Methods* 24 (2025). https://doi.org/10.1177/16094069251337582.

Long, Darui. "Ethics in Humanistic Buddhism: Studies on Venerable Taixu and Master Hsing Yun's Views on Ethics." *Hsi Lai Journal of Humanistic Buddhism* 3 (2002): 333–51. https://ir.uwest.edu/s/index/item/424.

Los Angeles Chronicle. "WASC Approves New University of the West Buddhist Chaplaincy Program." Published August 14, 2008. https://pluralism.org/news/wasc-approves-new-university-west-buddhist-chaplaincy-program.

Louw, Daniel J. "The Hermeneutics of Intercultural Pastoral Care: From 'Psyche' to 'Position' (Habitus) within the Healing Dynamics of Life (Cura Vitae)." *Scriptura: Journal for Contextual Hermeneutics in Southern Africa* 103, no. 1 (2010): 175–88. https://doi.org/10.10520/EJC100519.

Loy, David. *The Great Awakening: A Buddhist Social Theory*. Boston: Wisdom Publications, 2003.

McKnight, Daphna. "The ABCs of CPE – What is CPE & How Do I Apply?" International Buddhist Chaplains Foundation. Published April 6, 2020. https://ibcfusa.org/wp-content/uploads/2020/04/The-ABCs-of-CPE-v.-4.6.20.pdf.

Monnet, Michael. "Developing a Buddhist Approach to Pastoral Care." In *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*, edited by Cheryl A. Giles and Willa B. Miller, 231–46. New York: Oxford University Press, 2015.

Mosher, Lucinda A. "Toward a Pedagogy of Interfaith Chaplaincy." *Reflective Practice: Formation and Supervision in Ministry* 37 (2017): 112–25.

Nāgārjuna. *Nāgārjuna's Middle Way: The Mūlamadhyamakakārikā*. Translated by Mark Siderits and Shōryū Katsura. Classics of Indian Buddhism. Boston: Wisdom Publications, 2013.

Naropa University. "Center for Contemplative Chaplaincy." Accessed March 11, 2026. https://www.naropa.edu/programs/graduate-academics/divinity/center-for-contemplative-chaplaincy/.

National Health Security Office. "NHSO to partner with Arokhayasala Khampramong Temple in delivering palliative care." Published February 16, 2024. https://eng.nhso.go.th/view/1/DescriptionNews/NHSO-to-partner-with-Arokhayasala-Khampramong-Temple-in-delivering-palliative-care/596/EN-US.

Network of Buddhist Organisations. "Chaplaincy." Accessed March 12, 2026. https://www.nbo.org.uk/resources/chaplaincy/.

New York Zen Center for Contemplative Care. "About Us." Accessed March 11, 2026. https://zencare.org/about-us.

Nhat Hanh. *Peace Is Every Step: The Path of Mindfulness in Everyday Life*. Berkeley: Parallax Press, 1991.

Nhat Hanh. *Vietnam: Lotus in a Sea of Fire*. New York: Hill and Wang, 1967.

NHS England. "NHS Chaplaincy – Guidelines for NHS Managers on Pastoral, Spiritual and Religious Care." Last modified August 14, 2023. https://www.england.nhs.uk/long-read/nhs-chaplaincy-guidelines-for-nhs-managers-on-pastoral-spiritual-and-religious-care/.

Noon, Edward J. "Interpretive Phenomenological Analysis: An Appropriate Methodology for Educational Research?" *Journal of Perspectives in Applied Academic Practice* 6, no. 1 (2018): 75–83. https://doi.org/10.14297/jpaap.v6i1.304.

Nyanasatta Thera, trans. "Satipatthana Sutta: The Foundations of Mindfulness (MN 10)." Access to Insight (BCBS Edition). Last modified December 1, 2013. https://www.accesstoinsight.org/tipitaka/mn/mn.010.nysa.html.

Patton, John. *Pastoral Care in Context: An Introduction to Pastoral Care*. Louisville: Westminster John Knox Press, 1993.

Pilaikiat, Raweewan, Warunee Fongkaew, Hunsa Sethabouppha, Pikul Phornphibul, and Joachim G. Voss. "Development of a Buddhist Spiritual Care Model for People at the End of Life." *Journal of Hospice & Palliative Nursing* 18, no. 4 (2016): 324–31.

Pittman, Don A. *Toward a Modern Chinese Buddhism: Taixu's Reforms*. Honolulu: University of Hawai'i Press, 2001.

Piyadassi Thera, trans. "Dhammacakkappavattana Sutta: Setting in Motion the Wheel of Truth (SN 56.11)." Access to Insight (BCBS Edition). Last modified November 30, 2013. https://www.accesstoinsight.org/tipitaka/sn/sn56/sn56.011.piya.html.

Power, Mark. "Buddhist Chaplaincy in a Christian Context: A Personal Journey." In *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work*, edited by Cheryl A. Giles and Willa B. Miller, 63–71. Boston: Wisdom Publications, 2012.

Puchalski, Christina, Betty Ferrell, Rose Virani, Shirley Otis-Green, Pamela Baird, Janet Bull, Harvey Chochinov, et al. "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference." *Journal of Palliative Medicine* 12, no. 10 (2009): 885–904.

Pye, Jonathan. "Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No." *Implicit Religion* 11, no. 2 (July 2008): 193–94. https://doi.org/10.1558/imre.v11i2.193.

Quadri, Nasreen S., Elizabeth Kitamura, Allison Benjamin, Naima Hassan, and Laura Heinemann. "Expanding Access through Representation and Inclusion in the Spiritual Care Workforce: An Exploratory Qualitative Examination of Insights from Somali Muslim Chaplains and Their Educators in the USA." *Journal of Religion and Health* 63, no. 6 (2024): 4559–79. https://doi.org/10.1007/s10943-024-02134-0.

Reid, Anne-Marie, Jeremy M. Brown, Julie M. Smith, Alexandra C. Cope, and Susan Jamieson. "Ethical Dilemmas and Reflexivity in Qualitative Research." *Perspectives on Medical Education* 7, no. 2 (2018): 69–75. https://doi.org/10.1007/s40037-018-0412-2.

Saldaña, Johnny. *The Coding Manual for Qualitative Researchers*. 4th ed. London: SAGE Publications, 2021.

Sanford, Monica, and Nathan Jishin Michon. "Buddhist Chaplaincy." In *Oxford Research Encyclopedia of Religion*, edited by John Barton. New York: Oxford University Press, 2019. https://doi.org/10.1093/acrefore/9780199340378.013.641.

Sanford, Monica, Elaine Yuen, Cheryl Giles, Hakusho Johan Ostlund, and Alex Baskin. *Mapping Buddhist Chaplains in North America*. Waltham: Chaplaincy Innovation Lab, 2022. https://chaplaincyinnovation.org/resources/ebooks/mapping-buddhist-chaplains.

Sanford, Monica. “The Practice of Dharma Reflection among Buddhist Chaplains: A Qualitative Study of ‘Theological’ Activity among Non-Theocentric Spiritual Caregivers.” PhD diss., Claremont School of Theology, 2018.

Schmidt, Patrick. “From Doxastic to Epistemic: A Typology and Critique of Qualitative Interview Styles.” *Qualitative Inquiry* 25, no. 10 (2019): 1012–13.

Scoville-Pope, Bryan. “The Three Lotuses: Knowledge, Ethics, and Compassion as a Framework for the Education of Buddhist Clergy in the West.” PhD diss., University of the West, 2018.

Shiu, Henry C. H. “The Emergence of Buddhist Chaplaincy Training in Ontario, Canada.” *Canadian Journal of Buddhist Studies* 17 (2022).

Shogaku Zen Institute. “SZI Professional Chaplain-Specific FAQs.” Accessed March 11, 2026. https://www.shogakuzen.org/chaplaincyspecific-faqs.

Sivaraksa, Sulak. *Seeds of Peace: A Buddhist Vision for Renewing Society*. Berkeley: Parallax Press, 1992.

Smith, Jonathan A., and Mike Osborn. “Interpretative Phenomenological Analysis.” In *Qualitative Psychology: A Practical Guide to Research Methods*, edited by Jonathan A. Smith. London: SAGE Publications, 2008.

Smith, Jonathan A., Paul Flowers, and Michael Larkin. *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE Publications, 2009.

Smith-Penniman, Adele. “Buddhist Resources in Pastoral Care.” DMin diss., Andover Newton Theological School, 2006.

Starnaman, Sabrina. Review of *Kalyāṇamitra: A Model for Buddhist Spiritual Care,* by Monica Sanford. *The Journal of Pastoral Care & Counseling* 77, nos. 3–4 (2023): 185–86. https://doi.org/10.1177/15423050231206557.

Sullivan, Winnifred Fallers. *A Ministry of Presence: Chaplaincy, Spiritual Care, and the Law*. Chicago: University of Chicago Press, 2014.

Swanson, Paul L. *Foundations of T’ien-T’ai Philosophy: The Flowering of the Two Truths Theory in Chinese Buddhis*m. Fremont, CA: Jain Publishing Co., 1989.

Taniyama, Yozo. “The Vihāra Movement: Buddhist Chaplaincy and Social Welfare in Japan.” In *Buddhist Care for the Dying and Bereaved*, edited by Jonathan S. Watts and Yoshiharu Tomatsu, 75–94. Boston: Wisdom Publications, 2012.

Tekbaş, Aysun, Arian Mauntel, Utz Settmacher, Teresa Festl-Wietek, Anne Herrmann-Werner, Bipin Doshi, and Marie von Lilienfeld-Toal. “Intersection of Religious Beliefs and Healthcare in Germany: A Guide to Integrating Religious Diversity in Medical Practice.” *Cureus* 17, no. 4 (2025). https://doi.org/10.7759/cureus.82932.

Thanissaro Bhikkhu. *The Buddhist Monastic Code*. Vol. 1. Valley Center: Metta Forest Monastery, 2013.

Thanissaro Bhikkhu, trans. “Kucchivikara-vatthu: The Monk with Dysentery (Mv 8.26.1-8).” Access to Insight (BCBS Edition). Last modified 30 November 2013. http://www.accesstoinsight.org/tipitaka/vin/mv/mv.08.26.01-08.than.html.

Thapa, Shanker. “Master Hsing Yun of Fo Guang Shan and the Development of Humanistic Buddhism.” *In Taiwan Today*, edited by Anita Sharma and Sreemati Chakrabarti, 205–17. London: Anthem Press, 2010.

Thornton, Edward E. *Professional Education for Ministry: A History of Clinical Pastoral Education*. Nashville: Abingdon Press, 1970.

Travagnin, Stefania. “Humanistic Buddhism (Rensheng Fojiao 人生佛教 / Renjian Fojiao 人間佛教).” In *Oxford Research Encyclopedia of Religion*, edited by John Barton. New York: Oxford University Press, 2022. https://doi.org/10.1093/acrefore/9780199340378.013.635.

Trinlae, Lozang. “Prospects for a Buddhist Practical Theology.” *International Journal of Practical Theology* 18, no. 1 (2014): 7–22. https://doi.org/10.1515/ijpt-2014-0002.

Trungpa, Chögyam. *The Myth of Freedom and the Way of Meditation*. Berkeley: Shambhala, 1976.

Tsai, Chang-Hsiung. “Humanistic Buddhism in Practice Hospice Care and Buddhist Chaplaincy in Taiwan.” In *Studies on Humanistic Buddhism: Theory and Practice of Venerable Master Hsing Yun*, 420–21. Kaohsiung: Fo Guang Culture Enterprise, 2014.

Turner, Alicia. *Saving Buddhism: The Impermanence of Religion in Colonial Burma*. Honolulu: University of Hawai‘i Press, 2014.

Uchimoto, Kōyū. “Training of Buddhists to Deal with the Patients: A Case at Ryukoku University’s ‘Practical Training Program for Interfaith Chaplains.’” *The Journal of the Nippon Buddhist Research Association* 88 (2024): 103–30. https://doi.org/10.15033/nbra.88.0__103_.

Ugiagbe, Iyore M., Helen T. Allan, Michael Traynor, and Linda Collins. “Thinking Theoretically in Nursing Research-Positionality and Reflexivity in an Interpretative Phenomenological Analysis (IPA) Study.” *Nursing Inquiry* 32, no. 1 (2025): e12684. https://doi.org/10.1111/nin.12684.

University of the West. “About UWest.” Accessed March 11, 2026. https://www.uwest.edu/about-uwest/.

University of the West. “Buddhist Chaplaincy Graduate Programs.” Accessed March 11, 2026. https://www.uwest.edu/academics-buddhist-chaplaincy-grad/.

University of the West. “Master of Divinity in Buddhist Chaplaincy (MDiv).” Accessed March 11, 2026. https://www.uwest.edu/mdiv-masters-of-divinity/.

University of the West. “Strategic Plan.” Accessed March 11, 2026. https://www.uwest.edu/about-strategic-plan/.

Watson, Burton, trans. *The Vimalakīrti Sūtra*. New York: Columbia University Press, 1997.

Watson, Tony J. “Managing Identity: Identity Work, Personal Predicaments and Structural Circumstances.” *Organization* 15, no. 1 (January 2008): 121–143. https://doi.org/10.1177/1350508407084488.

Wells, Chloe, William Van Gordon, and Paul Barrows. “Mindfulness and Buddhist Principles in Oncology: Risks, Misconceptions and Recommendations for Ethical Integration.” *Journal of Psychosocial Oncology* 44, no. 2 (2026): 248–63. https://doi.org/10.1080/07347332.2025.2551625.

Wepener, Tiani. “Interpreting Adolescent Experience: Methodological Lessons from IPA in Geography Education Research.” *The Professional Geographer* 77, no. 5 (2025): 557–68. https://doi.org/10.1080/00330124.2025.2539213.

Whitaker, Justin. “Columbia University Hosts Buddhist Chaplaincy Conference in New York.” Buddhistdoor Global. Published May 7, 2019. https://www.buddhistdoor.net/news/columbia-university-hosts-buddhist-chaplaincy-conference-in-new-york.

Wickremeratne, Ananda. *The Genesis of an Orientalist: Thomas William Rhys Davids and Buddhism in Sri Lanka*. Delhi: Motilal Banarsidass, 1984.

Wierstra, Iris R., Carmen Schuhmann, Jaelle Collard, Ben Oosterom, and Gaby Jacobs. "Interfaith Collaboration: Boundary Crossing in a Participatory Action Research Project with Health Care Chaplains in the Netherlands." *Journal of Religion and Health* 64, no. 2 (2025): 1068–86. https://doi.org/10.1007/s10943-024-02185-3.

Wright, Steven. "Interpretative Phenomenological Analysis: Completing and Enhancing the Process with ATLAS.ti." In *SAGE Research Methods Datasets*. London: SAGE Publications, 2024.

Xu Baofeng, ed. "Humanistic Buddhism (人間佛教)." In *Contextual Dictionary of Chinese Cultural Knowledge*. Singapore: Springer Nature, 2025. https://doi.org/10.1007/978-981-99-5009-6_10165.

Yamaoka, Seigen. "Spirituality and Spiritual Care: A Buddhist Perspective." *Reflective Practice: Formation and Supervision in Ministry* 33 (2013): 1–10.

Yao, Yushuang, and Richard F. *Gombrich. Chinese Buddhism Today: Conservatism, Modernism, Syncretism and Enjoying Life on the Buddha's Light Mountain*. Sheffield: Equinox Publishing, 2022.

Yardley, Lucy. "Demonstrating Validity in Qualitative Psychology." In *Qualitative Psychology: A Practical Guide to Research Methods*, edited by Jonathan A. Smith, 235–51. London: SAGE Publications, 2008.

Yardley, Lucy. "Dilemmas in Qualitative Health Research." *Psychology & Health* 15, no. 2 (2000): 215–28. https://doi.org/10.1080/08870440008400302.

Yin Shun. *The Way to Buddhahood: Instructions from a Modern Chinese Master*. Translated by Wing H. Yeung. Boston: Wisdom Publications, 1998.

Zelliot, Eleanor. *Ambedkar's World: The Making of Babasaheb and the Dalit Movement*. New Delhi: Navayana, 2013.

Zen Peacemakers. "The Three Tenets." Accessed April 23, 2026. https://zenpeacemakers.org/three-tenets/.

Zhen Guan. "Buddhist Chaplaincy in the United States: Theory-Praxis Relationship in Formation and Profession." *Journal of International Buddhist Studies* 13, no. 1 (2022): 44–59.

Ziporyn, Brook A. *Emptiness and Omnipresence: An Essential Introduction to Tiantai Buddhism*. Bloomington: Indiana University Press, 2016.

Appendix A: Definitions of Key Terms

Note: Key terms are defined to clarify how they are used in the study and to reduce conceptual ambiguity across the fields of Buddhist studies, chaplaincy education, and qualitative research. Several terms (e.g., spiritual care, chaplaincy, monastic, CPE) can carry different meanings across institutional and cultural contexts. The definitions below are offered as working definitions grounded in the scope of this project.

Buddhist Monastics. In this study, "Buddhist monastics" refer to individuals who have undertaken a formal, publicly recognized monastic commitment within a Buddhist tradition, typically marked by ordination and participation in a renunciant form of life. The term includes Buddhist monks and nuns and may include novices, depending on participants' self-identification and the recognition of their monastic status within their lineage and community. This definition prioritizes participants' lived vocational identity and communal recognition rather than assuming uniform ordination standards across Buddhist traditions.

Buddhist Renunciate/Renunciation. The term "Buddhist renunciate" is used to emphasize the vocational and ethical orientation of monastic life as a commitment to renunciation. In this dissertation, "renunciation" does not mean withdrawal from compassion or social engagement; rather, it refers to a disciplined way of life shaped by vows/precepts, communal or lineage obligations, and ongoing spiritual training (e.g., meditation, study, ritual, ethical discipline). The term is used analytically to highlight the ways monastic commitments may shape (and at times complicate) clinical role expectations.

Clinical Practice/Clinical Encounters. In this study, "clinical practice" means the direct caregiving activities that participants do in healthcare settings during their CPE unit(s), such as visiting patients, supporting families, helping staff, responding to crises, and other chaplaincy-related tasks allowed by the training site. "Clinical encounters" refer more narrowly to concrete interactions (e.g., a bedside visit, a conversation with family members, or a debrief with staff) that participants may reflect on in supervision and in the research interview.

Chaplaincy/Clinical Spiritual Care. "Chaplaincy" and "clinical spiritual care" are used in overlapping ways to describe professional spiritual care within institutional settings such as hospitals, hospices, prisons, or the military. In this study, the term "clinical spiritual caregiver" refers to a person functioning in a role (trainee or professional) that offers spiritual, emotional, and existential support, often within an interdisciplinary care team. The term is intentionally broad and does not assume that caregiving is conducted using explicitly religious language or rituals in every encounter.

Spiritual Care. "Spiritual care" refers to practices of presence, listening, assessment, and support that attend to a person's spiritual, existential, religious, and meaning-related concerns, particularly in contexts of illness, suffering, loss, moral distress, or end-of-life decision-making. In this dissertation, spiritual care may include (but is not limited to)

religious ritual, prayer/chanting, meditation guidance, ethical consultation, grief support, and meaning-making conversations. The term is used descriptively, recognizing that participants may define "spiritual" differently and that spiritual care in clinical settings is often shaped by institutional policies and patient-centered consent.

Buddhist Teachings and Practices (Buddhist Resources). "Buddhist teachings and practices" refer to doctrinal, ethical, contemplative, and ritual resources drawn from Buddhist traditions that participants may mobilize in clinical work and CPE reflection. This includes, for example, teachings related to suffering (*dukkha*), impermanence, non-self/emptiness, compassion (*karuṇā*), lovingkindness (*mettā/maitrī*), non-harming, mindfulness, meditation disciplines, chanting, and lineage-specific texts or vows. The dissertation uses "Buddhist resources" as a shorthand for these teachings and practices as they are interpreted and enacted by participants in lived contexts.

Reflective Learning (CPE Reflection). "Reflective learning" refers to the structured processes within CPE through which trainees interpret and learn from clinical encounters. In this study, reflective learning includes supervision sessions, peer group processes, verbatim/case presentations, self-evaluation, and other CPE educational activities aimed at increasing self-awareness, relational competence, and caregiving effectiveness. The term underscores that learning in CPE is not only skill acquisition but also interpretive formation.

Supervision/CPE Supervisor (Educator). "Supervision" refers to the formal educational relationship in CPE in which a certified educator/supervisor supports trainees' learning through feedback, evaluation, and guided reflection on clinical practice and professional identity. The term "supervisor" (or "educator") in this dissertation denotes the person responsible for the trainee's learning and assessment within the CPE unit. This term is used without assuming a single supervisory style; participants' experiences may range from supportive to challenging and are treated as part of the phenomenon under study.

Cohort/Peer Group. "Cohort" (or "peer group") refers to the group of CPE trainees who participate in a unit together and engage in group reflection, interpersonal process learning, and mutual feedback. Because group dynamics are central to CPE pedagogy, the term is used to capture how participants experience peer learning, belonging, conflict, and support.

Healthcare Institutional Contexts. "Healthcare institutional contexts" refer to the organizational and cultural environment of healthcare settings in which chaplaincy operates, including policies, professional norms, clinical hierarchies, documentation systems, and interdisciplinary team structures. The term highlights that spiritual care is shaped not only by individual caregiver competence but also by institutional expectations, power relations, and administrative constraints.

Lived Experience. "Lived experience" refers to the embodied, relational, emotional, and interpretive dimensions of participants' experience as it is perceived and narrated by them.

In keeping with IPA, lived experience in this dissertation is not treated as raw "facts" alone but as experience already interpreted by the participant and further interpreted by the researcher through analytic engagement with interview data.

Meaning-Making. "Meaning-making" refers to the ways participants interpret events, relationships, and challenges, including how they articulate values, purpose, identity, and spiritual understanding in relation to CPE and clinical caregiving. In this study, meaning-making includes both explicit reflections (what participants say they learned or believe) and implicit interpretive patterns (how they frame dilemmas, growth, and role tensions).

Appendix B: Statistical Summary of Questionnaire Data

Respondent Demographics

		Count	Percentage
Gender			
Male		4	33.3%
Female		8	66.7%
Race/Ethnicity			
Asian		11	91.7%
White		1	8.3%
Age			
36–40		6	50%
41–45		1	8.3%
46–50		3	25%
Over 50		1	8.3%
Didn't answer		1	8.3%
Buddhist Tradition			
Mahāyāna	Chinese	5	41.7%
	Korean	2	16.7%
	Japanese	1	8.3%
	Vietnamese	1	8.3%
Theravāda	Thai	2	16.7%
Vajrayāna	Tibetan	1	8.3%
Status concerning CPE			
Doing the first unit		2	16.7%
Completed one unit		4	33.3%
Completed four units		3	25%
Completed five units		1	8.3%
Chaplain Resident & completed four units		1	8.3%
Board Certified Chaplain		1	8.3%

Responses to Likert-Scale Items

1. I am interested in Buddhist chaplaincy and its clinical practice.

	Count	Percentage
Strongly Disagree	4	33.3%
Disagree	0	0%
Neutral	2	16.7%
Agree	2	16.7%
Strongly Agree	4	33.3%

2. I hesitated/struggled with choosing a CPE program that would be appropriate for me.

	Count	Percentage
Strongly Disagree	3	25%
Disagree	3	25%
Neutral	3	25%
Agree	3	25%
Strongly Agree	0	0%

3. The CPE program I participated in met my expectations.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	1	8.3%
Neutral	0	0%
Agree	5	41.7%
Strongly Agree	6	50%

4. I am satisfied with my performance in the CPE program/clinical practice.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	1	8.3%
Neutral	3	25%
Agree	3	25%
Strongly Agree	5	41.7%

5. The clinical method of learning/experiential learning was helpful and instructive.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%

	Count	Percentage
Neutral	0	0%
Agree	5	41.7%
Strongly Agree	7	58.3%

6. Doing CPE/clinical practice challenged my self-image as a Buddhist monastic.

	Count	Percentage
Strongly Disagree	2	16.7%
Disagree	3	25%
Neutral	1	8.3%
Agree	2	16.7%
Strongly Agree	4	33.3%

7. Doing CPE/clinical practice helped me deepen my understanding of Buddhist principles and develop new insights.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Neutral	1	8.3%
Agree	4	33.3%
Strongly Agree	7	58.3%

8. I encountered some difficulties in fitting into the CPE program/clinical learning environment.

	Count	Percentage
Strongly Disagree	1	8.3%
Disagree	2	16.7%
Neutral	2	16.7%
Agree	3	25%
Strongly Agree	4	33.3%

9. It was helpful/meaningful to study/work with people from different religious backgrounds.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Neutral	0	0%
Agree	4	33.3%
Strongly Agree	8	66.7%

10. I was able to share/discuss Buddhist views with my CPE supervisor and cohort.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Neutral	2	16.7%
Agree	2	16.7%
Strongly Agree	8	66.7%

11. Patients from other faith traditions showed interest in Buddhism and my identity.

	Count	Percentage
Strongly Disagree	1	8.3%
Disagree	0	0%
Neutral	1	8.3%
Agree	7	58.3%
Strongly Agree	3	25%

12. I applied Buddhist approaches (meditation, chanting, aspiration prayer, etc.) in visiting patients.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Neutral	1	8.3%
Agree	5	41.7%
Strongly Agree	6	50%

13. Doing CPE/clinical practice helped me to think critically/interpretatively about Buddhist spiritual care and applied/engaged Buddhist practices.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Neutral	1	8.3%
Agree	4	33.3%
Strongly Agree	7	58.3%

14. I would like to take more CPE units/continue my clinical practice.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%

	Count	Percentage
Neutral	9	75%
Agree	1	8.3%
Strongly Agree	2	16.7%

15. I would like to become a Certified Clinical Chaplain/CPE Certified Educator.

	Count	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Neutral	6	50%
Agree	5	41.7%
Strongly Agree	1	8.3%

Appendix C: In Vivo Code List

Note: In vivo codes use the exact words of participants to capture their lived experience. Codes are organized alphabetically with participant attribution.

Code	Participant	Context/Quote
“a bodhisattva experience”	Faye	Describing the sense of wholeness with another human being that drew her to CPE
“a little bit lower”	Mona	Reframing the monastic-lay relationship in chaplaincy—serving rather than directing
“a wall”	Dora	The emotional barrier she discovered she had built to protect herself
“absolute direct benefit”	John	Contrasting hospital chaplaincy with monastery-based practice
“an atheist”	Faye	Self-description in a theist-dominated cohort
“anything that doesn’t break the major precept”	Faye	Principle guiding flexibility in clinical practice
“bearing witness”	Hope, Dora	The Zen Peacemakers tenet applied clinically
“be with their sufferings”	Lynn	The chaplain’s role as presence rather than fixing
“big words”	Faye	Referring to Buddhist terms like emptiness as too abstract for patients
“boundary”	Lynn, Dora	The professional limit that monastics struggle to maintain
“call me Yun”	Lynn	Negotiating how she is addressed in the hospital
“chaplain comes from the Catholic”	Mona	Awareness of the Christian origins of chaplaincy terminology
“compassionate action”	Hope	The integration of Buddhist and clinical values
“create a phantom city”	Faye	Using the Lotus Sutra parable to understand her role
“cross-cultural psychology”	Lynn	Essential knowledge for Buddhist chaplains
“cultural misconception”	Hope	Internal critique from Buddhists about chaplaincy as “social work”
“do not offer any teachings”	Lynn	The fundamental clinical rule she follows
“don’t expect people to respect us”	Lynn	Advice for monastics entering CPE
“emotion might be important”	Dora	Recognizing the need for emotional awareness in Asian contexts
“empty your cup”	Dora	Buddhist story shared with peers
“energy”	Lynn	What patients perceive from a compassionate

Code	Participant	Context/Quote
		chaplain
“fundamental puzzle”	Lynn	The ongoing negotiation between monastic and chaplain identities
“gem”	Wynn	Buddhism as something precious that patients may lack energy to receive
“go back to the foundation”	John	Wisdom and compassion as essential principles
“grounded”	Dora	The advantage of monastic formation
“hold them accountable”	Hope	Calling out institutions that claim interfaith values but maintain Christian practices
“how to bring that knowledge”	Lynn	The challenge of offering Buddhist wisdom without teaching
“I create a phantom city”	Faye	Understanding her role as creating temporary refuge
“I just do”	Mona	Responding to uncomfortable clinical situations
“I’m basically an atheist”	Faye	Theological otherness in a theist cohort
“impermanence”	Multiple	Core Buddhist concept observed directly in hospital
“interconnectedness”	John, Hope	Buddhist principle applied clinically
“interfaith instead of multifaith”	Hope	Distinction that shaped his positive CPE experience
“it is not a good environment”	Wynn	Hospital as limited setting for deep Buddhist practice
“it’s my skin”	Dora	The robe as identity
“karma”	John	The concept that cannot be explained to a grieving mother
“living the Dharma”	John	His teachers’ affirmation of chaplaincy work
“long way to go”	Wynn	The seed-planting metaphor and its limitations
“meet their needs, meet where they are at”	Faye	Guiding principle for patient care
“middle path”	Lynn	Buddhist language applied to resolving identity conflict
“mindfulness is equanimity”	Lynn	Distinguishing Buddhist mindfulness from clinical mindfulness
“multifaith instead of interfaith”	Hope	The model that respects chaplains’ religious identity
“no feeling”	Lynn	The monk who saw snow for the first time without emotion
“not a teacher”	Lynn	The chaplain’s role contrasted with the

Code	Participant	Context/Quote
		monastic role
“not knowing”	Dora, Hope	The Zen Peacemakers tenet of entering without preconceptions
“not to make them happy”	Lynn	CPE teaching that differs from Buddhist expectations
“observe the pain”	Hope	Teaching patients to work with pain through meditation
“outsider”	Faye	Her feeling in a theist cohort
“phantom city”	Faye	The Lotus Sutra parable that illuminated her clinical role
“positive energy”	Lynn	What patients perceive from a compassionate chaplain
“power-over”	Hope	Critique of proselytizing as religious dominance
“practical Buddhism”	Lynn	The critique that motivated her CPE journey
“profound teachings”	Lynn	What Buddhism offers that must be withheld clinically
“put your foot in other people’s shoes”	Mona	The essence of CPE learning
“real world”	Mona	Hospital as the place where learning is tested
“refer out”	Hope	The multifaith model’s mechanism for respecting boundaries
“Right View”	Wynn	The Eightfold Path element most applicable clinically
“see all the situations”	Wynn	Suffering, emptiness, and impermanence visible everywhere in the hospital
“self-talk”	Lynn	Internal Buddhist reflection during clinical encounters
“serving all sentient beings”	Lynn	Bodhisattva vow as justification for serving non-Buddhists
“stone impression”	Wynn	What patients may receive instead of the full “gem”
“surfing on the wave of the pain”	Hope	Teaching patients to work with pain
“the robe is not you”	Dora	Her supervisor’s challenge
“their shoes”	Mona	Learning to understand patients’ perspectives
“too big, too hollow”	Faye	Buddhist terms as too abstract for patients
“unconditional love”	Lynn	Buddhist values applied clinically
“we are equal”	Mona	The understanding CPE enables
“we are interconnected”	John, Hope	Foundational Buddhist principle for chaplaincy

Code	Participant	Context/Quote
“we do not teach them”	Lynn	The key clinical discipline
“we don’t fix patients”	Lynn	The chaplain’s role contrasted with fixing
“why we spend time”	Wynn	Questioning whether brief encounters are truly helpful
“wisdom and compassion”	John, Faye	Foundational principles for Buddhist chaplaincy
“work alongside”	Lynn	The chaplain’s role contrasted with monastic teaching
“your robe is not you”	Dora	Her supervisor’s challenging question

Appendix D: Thematic Code List

Note: Thematic codes represent patterns identified across participant narratives, organized alphabetically.

Thematic Code	Description	Participants
Adaptation of Buddhist Language	Using Buddhist concepts without Buddhist terminology	John, Hope, Lynn, Faye
Asian Patient Dynamics	Distinctive challenges and opportunities with Asian patients	Dora, Lynn, Faye
Atheist/Theist Tension	Feeling like an outsider in theist-dominated settings	Faye, John
Awareness of Feelings	Learning to recognize and work with emotions	Lynn, Dora
Bodhisattva Vow as Framework	Understanding chaplaincy as bodhisattva practice	Lynn, John, Faye
Boundary Struggles	Difficulty maintaining professional boundaries	Lynn, Dora
Brief Encounters	The limitation of hospital-based relationships	Wynn, Mona
Buddhist Concepts Visible in Hospital	Seeing suffering, impermanence, and emptiness directly	Wynn, Faye
Buddhist Terms Too Abstract	Recognizing that “big words” don’t help patients	Faye, Wynn, Lynn
Calling In/Out	Holding institutions accountable for interfaith claims	Hope
Chaplain as Counselor	Framing the role in psychological terms	Mona, Wynn
Chaplain as Listener	Emphasis on listening over speaking	Mona, Lynn
Chaplain as Not-Teacher	Distinction from monastic teaching role	Lynn, Mona, John
Children’s Hospital Context	Working primarily with families, not children	Wynn
Clinical Confidence Development	Trajectory from nervousness to confidence	Dora, Mona, Faye
Cohort as Support System	Peer relationships as essential support	Multiple
Compassion as Foundational	Core Buddhist value for chaplaincy	All participants
Compassion Perceived by Patients	Patients sensing “energy” or presence	Lynn, John
Cross-Cultural Psychology	Need to understand cultural differences	Lynn, Mona
Cultural Bias Against Buddhism	Patient prejudice based on tradition	Mona, Hope
Cultural Conditioning of	Asian norms limiting emotional	Dora, Lynn

Thematic Code	Description	Participants
Emotion	expression	
Dharma Reflection Challenge	Difficulty applying Buddhist texts clinically	Faye, Wynn
Discovering the Wall	Realization of emotional protection	Dora
Distinguishing Monastic and Chaplain	Clear role differentiation	Mona, Lynn
Emotional Awakening	Recovery of tears and feelings	Lynn, Dora
Emptiness in Clinical Context	Difficulty applying the emptiness concept	Faye, Dora
Energy/Presence	What patients perceive from compassionate chaplains	Lynn, John
English Language Challenge	Language as obstacle and stressor	Dora, Mona, Faye
Enneagram/Self-Knowledge Tools	CPE focus on self-understanding	Mona, Lynn
Equality Learning	Understanding self as “a little bit lower”	Mona
Failure as Learning	Painful experiences becoming teachers	Faye, Lynn
Family Focus in Pediatric Care	Working with parents, not children	Wynn
Feelings: Absence and Recovery	Lynn’s journey from no tears to tears	Lynn
Flexibility in Identity	Being Buddhist selectively	Faye, Mona
Four Noble Truths Applied	Clinical use of core Buddhist framework	John, Dora, Hope, Lynn
Gem and Stone Metaphor	Questioning whether patients truly receive Buddhism	Wynn
Groundedness as Advantage	Monastic stability in crisis	Dora, John
Group Facilitation Skills	Leading patient and staff groups	Dora
Hierarchy vs. Equality	Shift from monastic hierarchy to chaplain equality	Mona
Identity Confusion Risk	Potential loss of monastic identity	Lynn, Mona
Impermanence Observed	Death and change visible everywhere	Wynn, Faye
Integration of Theory and Practice	Connecting Buddhist learning with clinical work	Mona, Lynn, John
Interfaith Competence	Need to know other traditions	Mona, Lynn
Interfaith vs. Multifaith	Distinction shaping experience	Hope
Internal Buddhist Critique	Criticism from within tradition	Lynn, Hope
Karma: Clinical Limitations	Cannot explain karma to suffering families	John, Faye
Korean Christian Bias	Specific cultural-religious obstacle	Mona

Thematic Code	Description	Participants
Language Translation Challenge	Difficulty explaining Buddhist concepts	Dora, Faye
Limitations of Hospital Chaplaincy	Brief encounters, no follow-up	Wynn
Listening Skill Development	Learning to listen before speaking	Dora, Mona
Living the Dharma	Chaplaincy as Buddhist practice	John, Lynn
Lotus Sutra Application	Phantom City parable as clinical framework	Faye
Meditation as Clinical Tool	Teaching meditation to patients	Hope, Lynn, Faye, Wynn
Meditation Adaptation	Tailoring meditation to each patient	Lynn
Meditation Popularity	Patient openness to meditation	Wynn, Lynn
Meditation Requires Practice	Personal practice necessary for teaching	Lynn
Middle Path	Buddhist framework for identity balance	Lynn
Mindfulness in Clinical Settings	Adaptation of Buddhist practice	Lynn, Wynn
Misconceptions About Buddhists	Kung fu, proselytizing assumptions	Hope, Faye
Monastic Identity Visible	Robe as both identity and obstacle	Multiple
Motivation for CPE	Reasons for entering training	All participants
Multifaith Model	Respecting religious identity	Hope
Non-Attachment	Protection against burnout	Lynn
Not Knowing	Clinical stance of openness	Dora, Hope
Not-Fixing Role	Chaplain as present, not solving	Lynn, Mona, Faye
Observation Skill	Learning to observe patients	Wynn
Obstacles: Language, Culture, Appearance	Multiple barriers	Multiple
Open-Minded Tradition	Surprising patients with openness	Hope
Otherness Experience	Feeling foreign and alien	Faye, Mona
Outsider Feeling	Not belonging in theist cohort	Faye
Palliative Care Focus	Working with dying patients	Lynn, John
Patient Attachment	Patients wanting to continue relationship	Lynn
Patient Rejection	Being turned away	Hope, Faye, Mona
Peer Learning	Learning from and with cohort	Mona, Dora, Faye
Personal Practice Growth	CPE deepening Buddhist practice	Lynn, John
Phantom City Revelation	Understanding role through parable	Faye
Planting Seeds	Metaphor for brief encounters	Wynn, Lynn

Thematic Code	Description	Participants
Positive Energy	What patients perceive	Lynn
Power Dynamics	Critique of Christian dominance	Hope
Practical Buddhism	Testing teachings in real world	Lynn
Prayer Across Traditions	Learning to pray for non-Buddhists	Dora, Faye, Lynn
Presence as Intervention	Simply being with suffering	John, Faye, Lynn
Professional Boundaries	Learning to set limits	Lynn
Proselytizing Encounter	Being prayed over without consent	Hope
Psychology Background	Value of prior training	Lynn, Hope
Questioning Effectiveness	Is this truly helpful?	Wynn
Real World Learning	Hospital as field test	Mona, Lynn
Rebalancing Wisdom and Compassion	Critique of tradition's overemphasis on wisdom	Faye
Referral System	Multifaith model's mechanism	Hope
Research Orientation	Conducting studies on chaplaincy	Lynn
Respect: Earned, Not Given	Advice for monastics	Lynn
Right View Applied	Helping patients regain perspective	Wynn
Robe as Authority	Wearing full robes at Cedars-Sinai	Hope
Robe as Identity/Skin	Deep attachment to monastic attire	Dora, Wynn
Robe as Obstacle	Triggering patient resistance	Hope, Mona
Robe Negotiation	Supervisor requests to change	Dora, Wynn
Role Distinction	Monastic vs. chaplain	Mona, Lynn
Seed Planting	Hope for future benefit	Wynn, Lynn
Self-Care Challenge	Monastics' difficulty with self-care	Lynn
Self-Discovery Through CPE	Learning about oneself	Dora, Lynn, Mona
Self-Talk	Internal Buddhist reflection during visits	Lynn
Serving All Beings	Bodhisattva logic for serving non-Buddhists	Lynn
Six Harmonies	Monastic framework applied	Hope
Stone Impression	Limited impact of brief encounters	Wynn
Suffering Everywhere	Hospital as site of visible suffering	Dora, Faye, Wynn
Suffering Language	Avoiding "suffering" as too heavy	Hope
Supervisor as Challenger	Being pushed to grow	Dora, Faye, Lynn
Surprise of Open-Mindedness	Patients' unexpected discovery	Hope
Tears Discovery	Emotional awakening through CPE	Lynn
Three Jewels as Support	Refuge in tradition	Dora

Thematic Code	Description	Participants
Three Tenets of Zen Peacemakers	Framework for clinical practice	Dora, Hope
Translation Challenge	Making Buddhist concepts accessible	Hope, Lynn, Faye
Unconditional Love	Buddhist values applied	Lynn
Usefulness Metaphor	Wooden bucket, gem, stone	Faye, Wynn
Verbatim Challenge	Difficulty writing Buddhist reflections	Faye
Visible Monastic Identity	Robe, shaved head as a marker	Multiple
Western Monastic Context	Living outside the community	John
Wisdom and Compassion	Foundational principles	All participants
Wooden Bucket	Metaphor for Buddhism's adaptation	Faye
Working Alongside	Chaplain's role vs. teacher role	Lynn

Appendix E: Summary of Code Groups

Note: Code groups represent higher-order conceptual clusters that organize related thematic codes into superordinate themes for IPA analysis.

Code Group 1: Negotiating Visible Monastic Identity in Clinical Space

Code	Description
Robe as Identity/Skin	Deep attachment to monastic attire as extension of self
Robe as Authority	Wearing full robes as assertion of identity
Robe as Obstacle	Robe triggering patient resistance or assumptions
Robe Negotiation	Supervisor requests to change clothing
Visible Monastic Identity	Shaved head and appearance as marker
Misconceptions About Buddhists	Kung fu, proselytizing assumptions
Cultural Bias Against Buddhism	Specific prejudice based on tradition
Korean Christian Bias	Particular cultural-religious obstacle

Summary: This group captures the complex dynamics of being visibly Buddhist in clinical settings. The robe functions simultaneously as identity ("my skin"), authority, and obstacle. Participants negotiated institutional expectations (being asked to change), patient responses (curiosity or rejection), and cultural biases (Korean Christian prejudice). The visible marker of monastic identity is both a gift and a burden: it enables an authentic presence while also inviting assumptions that must be managed.

Code Group 2: The Emotional Awakening of Protected Selves

Code	Description
Discovering the Wall	Realization of emotional protection
Cultural Conditioning of Emotion	Asian norms limiting expression
Tears Discovery	Recovery of emotional capacity
Feelings: Absence and Recovery	Lynn's journey from no tears to tears
Awareness of Feelings	Learning to recognize emotions
No Feeling	Questioning monastic equanimity
Emotional Awakening	Transformation through CPE

Summary: Multiple participants described a profound shift in emotional awareness through CPE. Dora discovered the "wall" she had built; Lynn recovered from tears after decades without crying; Faye learned to stay with emotion rather than running from it. This group questions whether traditional monastic training may sometimes mask rather than transcend emotions and suggests that CPE offers a complementary formation—emotional awareness along with equanimity.

Code Group 3: Distinguishing Monastic and Chaplain Roles

Code	Description
Distinguishing Monastic and Chaplain	Clear role differentiation
Chaplain as Not-Teacher	Distinction from teaching role
Chaplain as Listener	Emphasis on listening over speaking
Chaplain as Counselor	Framing role in psychological terms
Not-Fixing Role	Being present, not solving
Work Alongside	Accompanying rather than directing
Hierarchy vs. Equality	Shift from high to “a little bit lower”
We Don’t Fix Patients	Core clinical understanding
Do Not Offer Teachings	Fundamental clinical discipline

Summary: This group describes participants’ understanding of how chaplaincy differs from traditional monastic-lay relationships. The chaplain does not teach, fix, direct, or control—but listens, accompanies, and works alongside. This marks a fundamental shift in identity for monastics accustomed to their roles as teachers and guides. Mona’s contrast between her approach and an untrained monastic’s “control, control, control” illustrates this distinction vividly.

Code Group 4: The Fundamental Puzzle of Balance

Code	Description
Fundamental Puzzle	Ongoing negotiation between identities
Middle Path	Buddhist framework for balance
Boundary Struggles	Difficulty with professional limits
Identity Confusion Risk	Potential loss of monastic self
Flexibility in Identity	Being Buddhist selectively
Patient Attachment	Patients wanting ongoing relationship
Professional Boundaries	Learning to set limits

Summary: This group addresses the core tension Lynn names as the “fundamental puzzle”—how to be both a good monastic and a good chaplain. Participants navigated this through clear role differentiation (Mona), selective identity expression (Faye), and gradual learning about boundaries (Lynn). The resolution is not final but ongoing: a “middle path” that honors both identities without collapsing them.

Code Group 5: Clinical Application of Buddhist Wisdom

Code	Description
Adaptation of Buddhist Language	Using concepts without terminology
Meditation as Clinical Tool	Teaching meditation to patients
Meditation Adaptation	Tailoring to each patient
Four Noble Truths Applied	Core framework clinically
Right View Applied	Helping patients regain perspective
Compassion as Foundational	Core Buddhist value
Compassion Perceived by Patients	Patients sensing "energy"
Energy/Presence	What patients perceive
Impermanence Observed	Death and change visible
Buddhist Concepts Visible in Hospital	Seeing teachings directly
Three Tenets of Zen Peacemakers	Framework for practice
Lotus Sutra Application	Phantom city as clinical model

Summary: This group captures how participants actually used Buddhist wisdom in clinical settings. The pattern is consistent: use the content, not the terminology; adapt meditation to each patient; let Buddhist concepts illuminate what is already visible (suffering, impermanence) rather than imposing them; let compassion be felt rather than stated. The Phantom City parable (Faye) exemplifies this—Buddhist teaching becomes a lens for understanding one's role, not a doctrine to be taught.

Code Group 6: The Challenge of Buddhist Language in Clinical Context

Code	Description
Buddhist Terms Too Abstract	"Big words" don't help patients
Karma: Clinical Limitations	Cannot explain to suffering families
Suffering Language	Avoiding term as too heavy
Emptiness in Clinical Context	Difficulty applying concepts
Translation Challenge	Making concepts accessible
Dharma Reflection Challenge	Difficulty writing verbatims
Verbatim Challenge	Buddhist reflection in CPE assignments
How to Bring That Knowledge	Challenge of offering without teaching

Summary: This group addresses the fundamental hermeneutic challenge of Buddhist chaplaincy: how to translate teachings developed in monastic contexts for clinical use. Participants consistently found that terms such as "emptiness" and "suffering" were too abstract or heavy for patients in crisis. The challenge is not to find better words but to

learn how to present Buddhist wisdom in forms patients can receive—through presence, meditation, and compassionate listening rather than teaching.

Code Group 7: The Interfaith Imperative and Its Challenges

Code	Description
Interfaith Competence	Need to know other traditions
Prayer Across Traditions	Learning to pray for non-Buddhists
Interfaith vs. Multifaith	Distinction shaping experience
Multifaith Model	Respecting religious identity
Referral System	Mechanism for boundaries
Calling In/Out	Holding institutions accountable
Power Dynamics	Critique of Christian dominance
Proselytizing Encounter	Being prayed over without consent
Chaplain Comes from Catholic	Awareness of Christian origins

Summary: This group captures participants' engagement with the interfaith reality of chaplaincy. Hope's distinction between interfaith and multifaith models was crucial—the latter respects religious identity rather than requiring its compromise. Participants learned to pray in Christian language, lead meditation for patients of all traditions, and work with chaplains from diverse backgrounds. Hope's critique of power dynamics and call for collective action represent the political dimension of this engagement: not merely surviving in a Christian-dominated field but transforming it.

Code Group 8: The Experience of Otherness and Outsider Status

Code	Description
Outsider Feeling	Not belonging in theist cohort
Atheist/Theist Tension	Theological difference
Otherness Experience	Foreign, alien, different
English Language Challenge	Language as obstacle
Patient Rejection	Being turned away
Cultural Bias Against Buddhism	Prejudice based on tradition
Korean Christian Bias	Specific obstacle

Summary: This group captures the multiple dimensions of otherness the participants experienced: as non-theists in theist settings, as non-native English speakers, as visibly Asian in predominantly white institutions, and as members of a minority tradition. Faye's feeling of being "an atheist" in a room full of believers, Mona's encounters with Korean Christian bias, and Dora's language struggles all reflect the additional burdens carried by Buddhist monastics in CPE—burdens that chaplains from majority traditions do not face.

Code Group 9: The Value of CPE for Buddhist Monastics

Code	Description
Living the Dharma	Chaplaincy as Buddhist practice
Practical Buddhism	Testing teachings in real world
Real World Learning	Hospital as field test
Personal Practice Growth	CPE deepening Buddhist practice
Equality Learning	Understanding self as "a little bit lower"
Self-Discovery Through CPE	Learning about oneself
Integration of Theory and Practice	Connecting learning with doing
Groundedness as Advantage	Monastic stability in crisis
Three Jewels as Support	Refuge in tradition

Summary: This group identifies what participants gained from CPE. For John, it was "living the Dharma" affirmed by his teachers. For Lynn, it was testing Buddhist learning in the "real field" and experiencing personal practice growth. For Dora, it was discovering the emotional "wall" she had built. For Mona, it was learning equality—that the chaplain is "a little bit lower" rather than higher. Despite struggles, all affirmed CPE's value for monastic formation.

Code Group 10: Questioning Effectiveness & Impact

Code	Description
Gem and Stone Metaphor	Questioning whether patients truly receive
Stone Impression	Limited impact of brief encounters
Why We Spend Time	Honest questioning of helpfulness
Planting Seeds	Metaphor for hope vs. evidence
Long Way to Go	Seed metaphor's limitations
Brief Encounters	Structural limitation of hospital care
Limitations of Hospital Chaplaincy	No follow-up after discharge

Summary: This group, distinctive to Wynn's narrative but resonating with others, questions whether brief hospital encounters truly benefit patients. The gem/stone metaphor captures the gap between what Buddhism offers and what patients may receive. The seed-planting hope is acknowledged but questioned: do seeds ever grow? This honest inquiry challenges complacent assumptions and points to the need for models that connect hospital chaplaincy with ongoing community care.

Code Group 11: Vision for Buddhist Chaplaincy Training

Code	Description
Cross-Cultural Psychology	Essential knowledge area
Meditation Requires Practice	Personal practice necessary
Meditation Adaptation	Teaching tailored to each patient
Rebalancing Wisdom and Compassion	Critique of tradition's emphasis
Knowing Ourselves to Be Open	Deep grounding enables openness
Resistance to Sectarian Training	CPE should remain interfaith
Respect: Earned, Not Given	Advice for monastics
Don't Expect People to Respect Us	Realistic expectation

Summary: This group synthesizes participants' recommendations for training Buddhist chaplains. Lynn emphasizes cross-cultural psychology, knowledge of other religions, and genuine meditation practice. Faye calls for rebalancing wisdom and compassion, reading texts through the lens of care. Mona argues against sectarian training—chaplains need interfaith competence. The consensus: deep grounding in one's own tradition enables openness to others, rather than foreclosing it.

Code Group 12: The Hermeneutic Challenge of Buddhist Chaplaincy

Code	Description
How to Bring That Knowledge	Offering wisdom without teaching
Adaptation of Buddhist Language	Using concepts without terminology
Translation Challenge	Making concepts accessible
Buddhist Terms Too Abstract	"Big words" don't help
Dharma Reflection Challenge	Difficulty applying texts
Phantom City Revelation	Finding clinical meaning in sutras
Practical Buddhism	Testing teachings in real world

Summary: This group, central to the dissertation's focus, addresses the interpretive challenge at the core of Buddhist chaplaincy. How does one take teachings developed in monastic contexts and apply them in clinical settings? How does one offer Buddhist wisdom to those who do not share Buddhist frameworks? The answer emerging from participants is not a better translation of terms but a different mode of presence—offering the content without the terminology, letting the teaching be embodied rather than stated, and finding clinical meaning in texts (like the Phantom City) rather than doctrinal formulations.

Appendix F: Information Sheet & Informed Consent

Information Sheet

The Hermeneutics of Clinical Practice among Buddhist Monastics: A Qualitative Study of Experiential Learning in the Practice of Buddhist Chaplaincy

Purpose

The purpose of this study is to examine the supervised clinical practice experience of Buddhist monastics involved in Clinical Pastoral Education (CPE) to understand their visions and self-interpretations and to generate a hermeneutical framework for the clinical training and practice of Buddhist chaplains. The project investigates Buddhist monastics and their hermeneutical approach concerning the engaged practice of Buddhist spiritual care in the clinical setting.

This study will analyze this reflective process and weave these insights into a well-grounded interpretive theory that is aimed at supporting the training and practice of Buddhist Chaplaincy. It will result in an overall hermeneutical framework that gives voice to the unique position and challenges faced by Buddhist practitioners working in the pastoral care field.

Eligibility

You are eligible to participate in this study if:

1. You are a Buddhist monastic.
2. You have completed OR are currently enrolled in a CPE program.

Your Participation

The study will consist of a general questionnaire and a follow-up interview for selected participants via an online video conference lasting no more than 40 minutes. All interviews will be recorded and transcribed. All data collected from participants will remain confidential**.** Your interview will be anonymized in the final reports unless you agree to use your name or an alias you prefer; you will receive a copy of the final results. You must return a signed Informed Consent before the interview can begin.

Contact

If you have any questions about this research, you can contact me at (626) 283-3073 or yishan.qian@my.uwest.edu. You may also contact my dissertation advisor, Dr. Jitsujo Gauthier, at (626) 571-8811 ext. 345 or jitsujog@uwest.edu. If you have questions about your rights as a participant in this study, you can contact Dr. Ashley E. Coleman, IRB Administrator, The Graduate Center/University of the West, at ashleyc@uwest.edu.

Informed Consent to Participate in Research

You are invited to participate in a doctoral dissertation research study, entitled "The Hermeneutics of Clinical Practice among Buddhist Monastics: A Qualitative Study of Experiential Learning in the Practice of Buddhist Chaplaincy." The study is being conducted by Yishan Qian (Ven. Guanliao) under the supervision of Dr. Jitsujo Gauthier of the University of the West, 1409 Walnut Grove Ave., Rosemead, CA 91770, jitsujog@uwest.edu, (626) 571-8811 ext. 345.

The purpose of this research study is to examine the supervised clinical practice experience of Buddhist monastics involved in Clinical Pastoral Education (CPE) to understand their visions and self-interpretations and to generate a hermeneutical framework for the clinical training and practice of Buddhist chaplains. Your participation will contribute to a better understanding of the hermeneutical approach concerning the practice of Buddhist monastics in the clinical setting. You are free to contact the investigator using the information below to discuss the study.

Yishan Qian, 1409 Walnut Grove Ave, Rosemead, CA 91770
(626) 283-3073, yishan.qian@my.uwest.edu

If you agree to participate:

The study will consist of a general questionnaire and a follow-up interview for selected participants via an online video conference lasting no more than 40 minutes. This interview will be audio-recorded and transcribed. A few email contacts may be requested to clarify statements in the original interview.

Your participation is intended to illuminate a well-grounded interpretive theory that supports the training and practice of Buddhist Chaplaincy. It will contribute to an overall hermeneutical framework that gives voice to the unique position and challenges faced by Buddhist practitioners working in the pastoral care field. Results of this research study will be shared with you via an emailed PDF.

Risks, Benefits, & Confidentiality

There are some possible risks or discomfort that could cause you to feel negative emotions such as discomfort, embarrassment, sadness, or anger. You may pause or end your participation in the study at any time if these feelings become too strong. The investigator will provide a referral to counseling upon request. You will not be compensated.

Your name, email address, and other personally identifiable information will be kept during the data collection phase. Audio recordings will only be used for transcription and then destroyed. No personally identifiable information will be publicly released. Your personal information will be used solely for tracking purposes.

When the results of the research are published or discussed at conferences, no information will be included that would reveal your identity. Unless you agree to use a Dharma name or an assumed name, as you prefer. Interview transcripts will be stored

indefinitely to facilitate further research on this topic, but personal information identifying the source of these data will be removed.

Participation or Withdrawal

Your participation in this study is voluntary. You may decline to answer any question, and you have the right to withdraw from participation at any time. If you do not want to participate, you may simply stop participating.

Contacts

If you have any questions about the study or need to update your email address, contact Yishan Qian at (626) 283-3073 or send an email to yishan.qian@my.uwest.edu. This study has been reviewed by the University of the West Institutional Review Board, and the study number is 02020.

Questions about Your Rights

If you have questions about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, Dr. Ashley E. Coleman, the chair of the Institutional Review Board, by phone at (626) 571-8811 ext. 2150 or email at ashleyc@uwest.edu.

Thank you!

□ I agree to have this interview recorded.

□ I prefer to be anonymous in the final reports.

□ I prefer to use a Dharma name or an assumed name: _____

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given an opportunity to ask questions, and all of my questions have been answered to my satisfaction. I have been given a copy of this form.

_____	_____	_____
Name of Participant (Printed)	*Signature of Participant*	*Date*

_____	_____	_____
Address	*Phone*	*Email*

_____	_____
Investigator's Signature	*Date (same as participant's)*

A signed copy of this document will be supplied for your records.

Appendix G: Recruitment Emails

Subject:
Inviting you to take part in my research study on Buddhist Chaplaincy and CPE

Dear Dharma Friends,

I hope this email finds you well.

My name is Yishan Qian (Ven. Guanliao). I am a doctoral candidate in the Doctor of Buddhist Ministry program at the University of the West. I am currently doing my dissertation research on the hermeneutics of clinical practice among Buddhist monastics and experiential learning in the practice of Buddhist Chaplaincy. I'm contacting you to invite you to take part in my research study.

I am looking for Buddhist monastics who have completed or are currently enrolled in a Clinical Pastoral Education (CPE) program. I am conducting a questionnaire about your learning experience and clinical practice in taking CPE. If you are interested, please consider using this link [online survey questionnaire] to answer the survey. You are welcome to forward this email to people you know who might be interested in participating and to learn more about the project.

This questionnaire should take approximately 5 minutes to complete. Your responses are fully confidential, and the results will be presented in a manner that maintains the anonymity of all participants. Remember, participation in this is completely voluntary, and you may skip questions that you do not wish to answer. However, I strongly encourage you to take this opportunity to review your experience with CPE.

If you'd like to participate in a follow-up interview (online) about your learning experience and your insight on Buddhist spiritual care and its clinical practice, or have any questions about the study, please contact me at (626) 283-3073 or yishan.qian@my.uwest.edu.

Thank you very much!

Sincerely,

Yishan Qian

Subject:
Invitation for participating in an interview about CPE

Hello Ven. _____

I am writing to invite you to participate in an interview (online) about your learning experience in taking CPE and your insights on Buddhist spiritual care and its clinical training. Please read the Informed Consent (see the attached fillable PDF form); you are free to ask any questions concerning the study. If you agree to participate in the interview, please sign and return the consent form to me by email.

There are some basic questions that I would like to ask; you are welcome to offer a different viewpoint or make suggestions. We may schedule a time later for a Zoom meeting. Please let me know when it is or would be convenient for you.
Thanks again for your participation!

Best,

Yishan

Re:

Hello Ven. _____

It's my pleasure to get in touch with you!

Please read the Informed Consent. You are free to ask any questions concerning the study. Please sign and return the consent form to me if you agree to participate in the interview.

There are some basic questions that I would like to ask; you are welcome to offer a different viewpoint or make suggestions.

We may schedule a time later for a Zoom meeting. Please let me know when it is or would be convenient for you.

Thanks again for your participation!

Sincerely,

Yishan

Appendix H: Questionnaire

This questionnaire should take approximately 5 minutes to complete. Your responses are fully confidential, and the results will be presented in a manner that maintains the anonymity of all participants. Participation in this process is voluntary, and you may skip questions that you do not wish to answer. However, I strongly encourage you to take this opportunity to review your experience in taking Clinical Pastoral Education (CPE). The information gathered through this questionnaire will be used in further studies.

About you…

a. What's your age?
- ○ Under 26
- ○ 26–30
- ○ 31–35
- ○ 36–40
- ○ 41–45
- ○ 46–50
- ○ Over 50
- ○ I prefer not to answer

b. What is your gender?
- ○ Male
- ○ Female
- ○ Non-binary/third gender
- ○ Prefer not to say
- ○ Other: _____

c. How do you describe your ethnicity?
- ○ Native American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Unknown
- ○ Don't wish to answer
- ○ Other: _____

d. Which tradition/school of Buddhism are you from?
- ○ East Asian Mahāyāna
  - ○ Chinese Buddhism
  - ○ Korean Buddhism
  - ○ Japanese Buddhism
  - ○ Vietnamese Buddhism
- ○ Theravāda
  - ○ Bangladesh

○ Cambodia
○ Laotian
○ Myanmar
○ Nepalese
○ Sri Lankan
○ Thai

○ Vajrayāna
○ Tibetan Buddhism

Other: _____

e. What's your status concerning CPE?
○ Doing my first CPE unit
○ Completed one CPE unit
○ Completed two or three CPE units
○ Completed four CPE units
○ Chaplain Resident
Other: _____

About your experience in CPE…

Please select one response to each question that most closely reflects your views.

1. I am interested in Buddhist chaplaincy and its clinical practice.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

2. I hesitated/struggled with choosing a CPE program that would be appropriate for me.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

3. The CPE program I participated in met my expectations.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

4. I am satisfied with my performance in the CPE program/clinical practice.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

5. The clinical method of learning/experiential learning was helpful and instructive.
Strongly Disagree
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

6. Doing CPE/clinical practice challenged my self-image as a Buddhist monastic.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

7. Doing CPE/clinical practice helped me deepen my understanding of Buddhist principles and develop new insights.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

8. I encountered some difficulties in fitting into the CPE program/clinical learning environment.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

9. It was helpful/meaningful to study/work with people from different religious backgrounds.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

10. I was able to share/discuss Buddhist views with my CPE supervisor and cohort.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

11. Patients from other faith traditions showed interest in Buddhism and my identity.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

12. I applied Buddhist approaches (meditation, chanting, aspiration prayer, etc.) in visiting patients.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

13. Doing CPE/clinical practice helped me to think critically/interpretatively about Buddhist spiritual care and applied/engaged Buddhist practices.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

14. I would like to take more CPE units/continue my clinical practice.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

15. I would like to become a Certified Clinical Chaplain/CPE Certified Educator.
○ Strongly Disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

Please share one experience from your CPE process that was significant in helping you learn something (such as a specific clinical visit, supervisory dialog, group discussion, verbatim, interfaith service, reading, etc.).

_____

_____

Please share any additional feedback, comments, or suggestions you may have related to this research and questionnaire design.

_____

_____

Thank you for taking this survey!
If you are interested in participating in an interview (online) or have any questions, please contact me at yishan.qian@my.uwest.edu.

Appendix I: Interview Questions

I. Background:

a. To start, can you tell me a little about your background as a Buddhist monastic?

b. Can you tell me the reason why you chose to take Clinical Pastoral Education (CPE)?

II. Direct Questions:

1. How do you think about the CPE program you have gone through/are participating in? What are the characteristics of the program?

2. How do you evaluate your performance and achievement in taking the CPE program? How are you getting along with your supervisor and cohort? Any surprises or challenges?

3. How comfortable or confident do you feel practicing clinical visits with patients? Do you do it spontaneously or only when assigned?

4. What are the advantages and obstacles for you as a Buddhist monastic participating in the CPE program and clinical practice? How do you handle them?

5. How do you understand the role of a Buddhist spiritual caregiver in your clinical practice? Are there any differences or contradictions with your role as a Buddhist monastic?

6. How do you interpret your clinical learning and practice experience from a Buddhist perspective? What specific Buddhist concepts, values, theories, texts, or stories have you applied in your clinical learning and practice?

7. How do you address and reflect on Buddhist terms such as suffering, emptiness, impermanence, etc. in your clinical learning and practice? Particularly when visiting a patient/patient's family.

8. How do you think about the effect and value of CPE for Buddhist monastics? How about the advantages and disadvantages?

9. What Buddhist principles, frameworks, and resources do you think are essential and effective in the clinical training of Buddhist chaplains?

10. What specific experiences, questions, and expectations do you have that can be used for reference in developing clinical Buddhist chaplaincy training programs?

Appendix J: IRB Approval

1409 Walnut Grove Avenue, Rosemead, CA 91770 • Tel: 626 571 8811 • Fax: 626 571 1413 • www.uwest.edu

Date: July 14, 2020 Approval Number: # 02020

Principal Investigator: Yishan Qian

Faculty Supervisor: Dr. Jitsujo Gauthier

Project Title: The Hermeneutics of Clinical Practice among Buddhist Monastics: A Qualitative Study of Experiential Learning in the Practice of Buddhist Chaplaincy

The University of the West Human Participants Protection Committee has reviewed the proposed use of human participants on the project identified above and has determined that the rights and welfare of human participants are adequately protected. The informed consent of participants will be obtained through a written or online consent form to be signed, either electronically or physically, by the subject (*unless otherwise noted below*).

____ Written Consent Waived ____Secondary Analysis of Pre-collected Data

Consent to be obtained by:

_x__ Introductory Letter

_x__Oral Statement

If modifications are made in the approved project, it is the investigator's responsibility to notify the Human Participants Protection Committee.

HPPC Approval Expires: 7/20/2021. If this research study continues beyond the approval period, you must request re-approval of this study prior to the expiration date.

Elizabeth Burke, Psy.D.

Ashley E. Coleman, Psy.D.

Jitsujo T. Gauthier, Ph.D.

University of the West Human Participants Protection Committee